A study of the degree of alignment between mental health practitioners' understanding of patients, resident in secure mental health hospital settings, who have been abused in childhood and/or adolescence

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APPENDIX
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Abstract

Childhood abuse and neglect, as suffered by in-patients of medium secure psychiatric hospitals, is an under-researched clinical variable within the literature. Associated study and work in this area is considered to be a core skill of the forensic mental health nurse (FMHN), as well as of other clinicians working in such hospitals.

The study undertook an examination of childhood abuse and neglect in three medium secure units (n=117), finding that 41% of the sample suffered abuse/neglect in childhood/adolescence. An examination of a wide range of patient characteristics in the units was also conducted, findings included observations of 94% of patients having committed a violent index offence, and 81.2% of patients being diagnosed with schizophrenia. A hypothesis test conducted on this data revealed a significant relationship between the gender of patients and abuse/neglect suffered in childhood.

A further analysis of inter-rater reliability was undertaken, of FMHN's and Nurse Consultants against a Benchmark nurse, in rating the severity of abuse suffered by in-patients. This revealed findings of both fair to moderate, and poor agreement, between the nurses, Nurse Consultants and Benchmark nurse.

Allied study of a range of clinicians knowledge and opinions concerning agreement or disagreement with statements related to concepts of abuse, mental disorder and violence revealed mixed results, dependent upon either a quantitative analysis indicating no variation amongst the clinician's, or qualitative analysis identifying some specific differences.

The study overall has concluded that the use of a mixed methodology is beneficial to examining consistency of agreement, and knowledge and opinions, regarding clinical phenomena amongst clinicians. The study makes recommendations in terms of adjustments to forensic educational curricula and clinical practice, regarding inclusion of more, and improved, information concerning childhood abuse and neglect.

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Chapter One: Introduction

1.0 Background

The background to this study is closely linked to this researchers own career in forensic mental health nursing. In 1990, as a student on a newly developed educational course (the Nursing Within Secure Environments Course, ENB course 770) I was reading an article concerning victimology, and its contribution to forensic psychiatry, when I happened upon the following quote:

> 'In view of the close relations between child abuse and later psychiatric disorder, on the one hand, and the high incidence of mental abnormality among offender patients, on the other, it is surprising how little attention has been paid to the incidence of abuse during childhood in mentally abnormal offenders.'
>
> *(Hamilton 1987 p 149)*

Having worked in a medium secure unit (MSU) for what was a relatively short time, just over one year at that point, this observation had a good degree of resonance with my own short experience of having worked with mentally disordered offenders (MDO's). It was interesting how frequently childhood or adolescent experience of abuse or neglect was related to me, by patients, as well as to other clinicians working within the MSU in which I was employed as a nurse. Such information was often related by patients during the taking of histories, or when involved in some form of intervention (usually one to one interventions as opposed to group). I maintained my interest in this area throughout the course and, into other courses of study I undertook during the early part of the 1990's. This interest was transferred into formal teaching and education of both undergraduates entering into a forensic placement, and postgraduates involved in the study of a forensic pathway on a Masters course, when this researcher was employed as a forensic nurse lecturer/practitioner in the mid 1990's.

My own research interests had begun to focus on the awareness of concepts of abuse suffered in childhood and adolescence amongst other clinicians, and the value of quantification of such abuse in determining the level of intervention required. As a consequence I undertook data

collection as part of two postgraduate educational courses at Birmingham University in a number of MSU's throughout England. The data collection was revealing of clinicians reporting frequent experience of having worked with patients who had been abused in childhood and adolescence, as well as prevalence of early abuse ranging between 25% and 40% amongst MSU populations. Despite this however, and in a climate during which mental health nurse education, and forensic service development was changing quickly, there appeared to be little within the literature or evidence base which specifically explored childhood abuse in MSU's. My own involvement in developing forensic mental health nurse (FMHN) educational curricula, during this period, enabled some inclusion of relevant teachings and literature, but this was primarily limited to the West Midlands area.

The aims of this research consequently emerged from an earlier recognition of the minimal address of the clinical variable of abuse in medium secure environments, as suffered in childhood/adolescence, and of its association with clinical and demographic variables such as diagnosis, ethnicity, legal status, violence, marital status and gender. Allied to this, a more focused research question began to be formulated related to consistency among clinicians in quantifying abuse, or determining severity of maltreatment suffered. Combined with my own clinical experience, I knew the case records from other MSU's to be revealing of a wide range of types, and what might be considered levels, of abuse and neglect which had been suffered by patients of MSU's in their childhood and/or adolescence. The importance of this determination of severity has been addressed within the literature (see Marshall and Barbaree 1989, Mullen et al 1993, Downs and Millar 1998) and will be covered in more detail in Chapter Two of this work. However this study began to be concerned with the lack of availability of any classification system regarding severity of maltreatment, which could be utilised by clinicians. In combining this concern, with a wish to examine nurses consistency and knowledge in quantifying maltreatment suffered by patients, the structure of a research project began to be formulated.

The overall aim of this project however was to examine a series of research questions and/or hypotheses that would contribute to improved care for patients. Whilst examination of nurses consistency, or reliability, in agreeing upon severity of maltreatment suffered by patients in

childhood and/or adolescence, would have answered questions linked to gaps in nursing knowledge or decision making ability, it would not reveal much of the MSU environment, or of the clinicians (other than nurses) working in such environments. Similarly prevalence of abuse suffered by patients, as well as profiles of patients and staff alike would, it was anticipated, contribute to a broader, richer, understanding of this MSU environment overall. A more detailed and larger project was thus designed. This project would incorporate patient data collection, and survey of a range of clinicians working in MSU's focusing upon both knowledge and opinions concerning concepts of abuse, as well as linked clinical variables of mental disorder and violence. The study, in exploring such areas could, it was anticipated, further describe and explore the overlap of areas such as prevalence of abuse, psychopathology, the educational preparation of staff, and knowledge and opinions concerning some of these areas.

1.1 Research Questions and Hypotheses

In summary of this stage of the research process the study had identified a number of research questions as follows:

- What is the prevalence of childhood abuse/neglect in a medium secure unit population
- What is the profile of a patient resident in a medium secure unit in terms of index offence, diagnosis, legal and marital status, ethnicity, gender and age
- What is the probability of having been both abused in childhood/adolescence and committing a violent index offence

The study was also interested in testing non-directional hypotheses related to associations between both clinical and demographic variables (where data obtained would produce a valid test), which could be stated as follows:

Hypothesis 1

There is a relationship between the variables of

a) Gender and index offence

b) Gender and abuse/neglect suffered

c) Legal status and abuse/neglect suffered

d) Index offence and abuse/neglect suffered

e) Marital status and abuse/neglect suffered

f) Ethnic origin and abuse/neglect suffered

g) Gender and marital status

in a medium secure unit population.

Therefore the null hypothesis Ho = no association between variables tested, and the alternative hypothesis would be H_1 = there is an association between the variables tested.

A series of specific research questions emerged from the study's interest in the profiles of staff working in such environments, as well as the inter rater reliability of staff in quantifying severity of maltreatment. These questions were as follows:

- What levels of work experience have staff had who are working in medium secure environments
- What educational preparation have nursing staff received to work in secure environments
- What is the range of post-registration education amongst nurses working in medium secure environments
- Do professional groups working in MSU's vary in terms of their knowledge and opinions regarding concepts of abuse, violence and mental disorder

One of the key questions of this research however related to a determination of levels of inter rater agreement amongst nursing staff, against a gold standard or benchmark, in respect to rating severity of maltreatment suffered by patients during childhood and adolescence.

1.2 Method

Clearly in generating sufficient data to answer both research questions and hypotheses a range of methods would have to be utilised. This study was in no way committed to a particular outcome, the work was exploratory in nature utilising non-directional hypotheses as opposed to directional, contributing in some way to the impartiality of the research (see Polit and Hungler 1995 p60). It was anticipated that the work would be descriptive as well as employing retrospective analysis of case notes. There was also a need to cover a wide geographical area in examining more than one MSU, to greater increase the representativeness of samples of both staff and patients studied within the research. For greater coverage of a range of medium secure units, and because of the descriptive, review, focus of the study a non-experimental design was employed. In examining the relationships between variables both quantitative and qualitative methods can be utilised. This was felt to be important to this work in that in employing a combination of methods a range of perspectives and alternative understandings could be achieved (see Playle 1995 p 984). The anticipation of a degree of triangulation in the work, (patient data collection, an examination of inter- rater reliability among nurses in rating severity of maltreatment, and an examination of knowledge and opinions amongst clinical staff in MSU's) lent itself to both qualitative and quantitative research methods as opposed to a purely positivist or interpretivist approach.

Chapter Two: Literature Review

2.0 Introduction

This review of the literature proposes to evaluate the progress of a range of theory and methodology associated with the topics of interest outlined in Chapter One. The type of research within this study is both descriptive and exploratory, and to this end this Chapter will attempt to provide an understanding of areas such as the development of forensic psychiatric services and forensic mental health nursing, the prevalence of childhood abuse and neglect in populations of secure settings, as well as association between childhood abuse, mental disorder and violence. The review will also examine the theory and elements of phenomenon such as abuse and violence, relate this examination to secure surroundings, and suggest reasons for such phenomenon, looking to the possibility of how certain things may change.

I am indebted to a range of librarians and library provision, notably those of Leicester De Montfort University, Birmingham University, Reaside MSU in the West Midlands, the Hutton Centre Middlesbrough, and Teesside University Library. As a consequence of this study many of these libraries are now routinely stocking journals which have been used extensively in this work such as:

- The Journal of Psychiatric and Mental health Nursing
- Criminal Behaviour and Mental Health
- Child Abuse and Neglect
- The British Journal of Forensic Psychiatry
- The Journal of Forensic Psychiatry
- The Journal of Interpersonal Violence
- Psychological Bulletin

There were a range of other more mainstream journals which were accessed regularly in compiling this review, notably the Journal of Advanced Nursing, Nurse Education Today, The Nursing Standard, Nursing Times (NT) Researcher, and The British Journal of Psychiatry.

The time frame employed in examining the majority of these journals, as well as many others, focused on the years between 1985 – 2001. This span of time was chosen as it began to become clear, at least in terms of nursing texts and journals, that from 1985 many nursing school libraries and data bases began to change, and to be moved into a range of locations, thus they became more difficult to access, as well as many journals being misplaced or lost which had been published prior to this time. The forensic mental health nursing literature, and research base is both emergent and growing. However, the bulk of this work is more recent than the broad review of other literature and research included in this work, and as a consequence is largely attributed to the last decade of development in this area. The parameters of the review were significantly extended via online searches of the literature through a range of now standardised CD-ROM services including Medline, Nursing and Allied, and Psychlit, again focusing upon the detailed literature. Particular online services were very useful, notably the Department of Health online services for official reports, as well as informative and useful sites such as NSPCC Inform, the online child protection resource. There needs to be evidence available to produce 'evidence based practice'. Shared clinical governance requires that al, professionals working in hospital settings have some form of access to research and literature which is related to their own clinical practice. My literature search linked to this research indicated clear value in clinically based resource areas being maintained in hospital settings. The value of such resources in clinical areas where significant change occurs frequently would appear to be even more important.

The study overall was concerned with definitional interpretations of concepts and associated with both childhood abuse and neglect, as well as violence and violent behaviour, and these themes are addressed within the review. Similarly an analysis of the range of methodology, and methodological problems, in the empirical literature associated with the concepts (as detailed) was a theme which the review wished to address. The review also sets out to illustrate the difficulty, expressed within the literature, in examining causation between concepts of mental disorder and childhood abuse, or abuse and violent offending. Consequently the literature examining mediating factors, which may improve understanding of such association is explored.

2.1 Medium Secure Unit Development

The milieu in which this work took place is very different from the care environments we would readily associate with those individuals suffering a mental illness. At time of writing the care network of secure psychiatric hospital environments in the United Kingdom, as well as environments and services allied to care of the mentally disordered offender (MDO) is extensive, and growing at a rapid rate. Despite this current rate of growth, developments in maximum medium and interim secure psychiatric care provision, can be viewed historically as a series of reactive measures. The literature focusing upon historical development of such services is testament to how reactive, as opposed to proactive, such service development has been. Grounds et al (1995 p 692) reminds us of the 1800 'Act for the safe custody of insane persons charged with offences', and of how this came about as a consequence of an attempted assassination of George III by James Hadfield. In 1972, the notorious prisoner Graham Young was convicted of Murder and other poisoning offences. These acts had occurred when Young had been on conditional discharge from Broadmoor maximum secure psychiatric hospital. Snowden (1990 p 1377), in his comprehensive history of regional secure units illustrates how this latter incident led to a fundamental review of legal provision and facilities for the treatment of MDOs. It can be argued that the development of Regional Secure units, or Medium Secure Units (MSUs) as they are now collectively known, almost 200 years after Hadfield, is as equally reactive as the 1800 Act.

Forensic Psychiatric service development, as portrayed within the literature from its beginnings, would appear to have been contingent upon a problem or catastrophic event or inquiry, which differentiates it somewhat from the philanthropic, some would say positive, development of other health care spheres. Forshaw and Rollin (1990 p 94) remind us of the development of the criminal wings in 1816 on the then new site of the Bethlem hospital (London) at St Georges Fields. These 'criminal wings' having filled to capacity led to the Act for the 'Better provision for the custody and care of criminal lunatics' in 1860, which in turn led to the building of Broadmoor Criminal Lunatic Asylum at Crowthorne in Berkshire. The three 'Special hospitals', as they have come to be known, can be seen as having been developed as a consequence of demand, related to both capacity and political and social

climate. The 'Special hospitals' in England are Broadmoor, Rampton and Ashworth, and the Carstairs State hospital is the Scottish equivalent. They all offer maximum secure psychiatric care. So as to place these hospitals into context with MSU development (the staff and patients of which being the focus of this work) it is worth reminding the reader of the rationale for Special hospitals and for the degree of security they offer;

> 'The Special hospitals, which form part of the NHS, provide an in-patient service under conditions of maximum security for mentally disordered offenders who are so dangerous that they would cause grave concern if managed elsewhere.'
>
> *(Snowden 1995 p 164)*

Rampton Hospital in Nottinghamshire opened after Broadmoor, and Park Lane and Moss Side (later merged to become Ashworth hospital) opened later. Many viewed the expansion of Ashworth hospital in Merseyside as a consequence of capacity issues related to the other two English Special hospitals. Certainly these capacity issues, as well as a range of inquiries examining standards of practice in the 1980s and 1990s began to focus attention upon security and treatment needs of those patients resident in Special hospitals. There are many changes which are occurring within these hospitals which have had, and are having, a direct impact upon the populations of MSUs. Badger et al (1999) have indicated a clear reduction in the number of patients resident in Special hospitals, from 2000 patients (in all four hospitals) in the early 1990s, to a figure reported by Taylor et al (1996) of nearer 1500 patients. This reduction is largely attributable to the discharge of patients with mental impairment (ibid.). The prevailing opinion with regard to the future of the Special hospitals in England is that they are best integrated within mainstream NHS provision, and in fact this has recently occurred in the three English Special hospitals

The development and impetus for medium secure service provision can be traced back to the Emery report (Ministry of Health 1961). Many have viewed this report as having extended the debate and argument related to the need for secure provision, and arrangements for the small number of patients requiring such care (Snowden 1990 p1376, Grounds et al 1995).

Grounds et al (ibid.) illustrated these problems when relating the pressure on the government to review provision for mentally abnormal offenders. Further to this the authors (ibid.) recognised the:

> 'growing evidence of need, of mentally abnormal offenders inappropriately placed because of a lack of facilities'
>
> *(Grounds et al 1995 p 710)*

The growing recognition of the lack of facilities led directly to the formation of two key working parties, which set out to address similar issues, publishing reports within a year of each other; the Glancy Report (DHSS 1974) and the Butler Report (Home Office /DHSS 1975). The rationale, findings, and recommendations from both reports have been well documented (Grounds 1990, Gunn and Taylor 1995, Faulk 2000). The key difference in the reports, which in turn affected the service expansion and delivery in England and Wales over the subsequent decade, related to bed numbers. Both reports had clearly recognised the gap between maximum-security Special hospitals and NHS hospitals, and the need to provide further development of existing secure services and the new build of regional secure services. The Glancy report had estimated the need to be 20 beds per million of the population, the Butler figure was double the Glancy estimate, from 1000 beds nationally to 2000 beds. Grounds et al (1995 p 712) remind us that the Department of health and Social Security (DHSS) fixed the number of beds in each regional health authority using the Glancy figure, as opposed to the numbers proposed within the Butler report. Seventeen years later the Reed report (Department of Health, Home Office 1992a) recommended an increase in numbers of regional secure beds in England and Wales to 1500. At time of writing (2000) the number of NHS medium secure beds in England and Wales is 1341 (DoH 2000/2001 p 2).

This positive focus upon medium secure unit development may have been as a consequence of the numerous inquiries into malpractice in the Special Hospitals, which have seemingly increased in volume over the period of accelerated medium secure unit development (see DHSS 1980, Chiswick 1982, Ritchie 1984, DoH 1992b). Such criticisms of practice within the Special hospitals have continued up to more recent times (see Fallon et al 1999). This

criticism of maximum secure care is perhaps the reason that those tracing historical development of medium secure services in the UK identify such units as key to the progress of secure care generally;

> 'These regional security units have become the focus of forensic psychiatry development in England'
>
> *(Gunn and Taylor 1995 p 1)*

Snowden (1990 p1375) actually argues that but for the political will and finance pumped into the regional secure unit building programme, forensic psychiatry in England and Wales would not have developed at all. The progress and expanding development of the medium secure services can be examined within the range of functions they serve as suggested by Snowden (1995);

> 'Firstly, it is the administrative teaching and research base for all staff. Secondly, it is the clinical base for those staff who are primarily involved with the community forensic psychiatry service. Thirdly, it is the in-patient resource.'
>
> *(Snowden 1995 p 172)*

Admission criteria for medium secure units differed to maximum secure units primarily in the admission being for the purpose of assessment. Further to this a level of security, i.e. medium, was deemed to be appropriate, and the patient would ordinarily have, or be thought to have a mental disorder, and be detainable under a section of the Mental Health Act (1983), (See Snowden 1995).

Grounds et al (1995 p716-717) have made some generalizations concerning admission criteria, which concur with Snowden (1995 p176) and further identify that the type of presenting behaviour will likely be violence toward others. These medium secure units in the 1980's were new units, new hospital provision, and early planners and commissioners recognised the need for a different approach to avoid the growth of negative cultures and institutionalization. Grounds et al (1995 p710) recognised the efforts of a small but growing band of 'product

champions' among psychiatrists who had skills and training in forensic psychiatry, but had worked outside of the Special Hospital system. Their counterparts in nursing are sadly largely ignored within the literature, Tony Hillis in the West Midlands, John Parry in Merseyside and Jim McIntegart in Northhamptonshire, to name but three. Such product champions in nursing had the daunting task of establishing quality services, and recruiting staff who had an understanding of the need to balance security and therapy, as well as effectively managing violence and aggression (see McHugh et al 1995), learn lessons from acts of deliberate self harm (see Garner and Butler 1994) and assess the risk an individual may present (see McClelland 1995).

The recognition of the need for greater numbers of nursing staff in such units helped the situation, and the DHSS were persuaded to accept higher than usual nurse to patient staffing ratios (see Grounds et al 1995 p711). It had begun to be recognised from the outset of medium secure service development that the nursing staff would require different sets of skills, and these will be discussed later in this work as would be expected from a study which partly examines judgement and knowledge base among nurses and other clinicians in such environments. Snowden (1995) summarises this point well, and further illustrates the task that those involved in the recruitment of appropriate nursing staff had in the early days of this new service development;

> 'It is the nursing staff who provide the first line of security through their skills and expertise in planning nursing strategies, setting limits, anticipating incidents and dealing with problems when they occur.'
>
> *(Snowden 1995 p 175)*

Nurses, and a range of other clinicians had worked in forensic practice (maximum secure hospitals and prisons) for many years, prior to the development of the MSUs. However the accelerated growth in forensic service provision during the 1980's and 1990's has led to a further evolution of forensic nursing, to a point where this type of nurse has developed a greater range of skills in both in-patient settings, and the community (see Cope 2001).

2.2 Two Decades of Forensic Mental Health Nurse Development

As forensic mental health care provision has developed into the 1980's, 1990's and into the early years of this century, so has the literature and research examining and debating the role and competencies required by the Forensic Mental Health Nurse (FMHN). This development however has been gradual, and as late as 1986, Niskala (1986) was forced to use the curricula of general, and generic psychiatric nursing programmes in British Columbia to identify the competencies and skills required by nurses working in forensic areas, in the absence of specific forensic mental health nursing programmes. In her work Niskala sampled nurses, employers, psychiatrists, psychologists and social workers working in general, psychiatric and forensic areas. The sample was asked to rank a list of thirteen competencies, which had been generated through a previously organised workshop, based around designing a curriculum. Ten nurses had been involved in this workshop, a combination of registered nurses (RN) and registered psychiatric nurses (RPN). Niskala herself critisises this method as limited, in that the group involved in the workshop generated numerous competency statements, with the consequent result of not identifying specific core competencies.

A further criticism of her method, relates to the use of both RN's and RPN's, the RN's experience of mental health curricula being limited in nature.

Within Niskala's work the nurses weighted the following competencies more heavily than any others;

- Communicate effectively
- Maintain security
- Perform nursing process
- Maintain professional role
- Maintain records
- Plan / participate in programmes
- Psychiatric nursing modalities
- Counselling

- Diagnostic and treatment modalities
- Conduct and participate in groups
- Instruct offenders
- Administration function
- Research

(From Niskala 1986 p 405)

Interestingly within the weighting scale used by Niskala 'instructing offenders' and 'administration' received equal weighting, research received the least weighting. Among the least regarded skills were provision of 'family counselling' and 'carrying out selected therapies'. Niskala recognised the limitations of her work as only 'one' way of identifying skills expected of nurses working in forensic areas, and she further recognised that future work would likely look to specific requirements of specific areas. Perhaps more telling is her conclusion that many nurses who perceive themselves to be competent already could perhaps benefit from study at the level of bachelor's or masters. This line of thinking was finding favour in the United Kingdom at this time, and would emerge in the form of Project 2000, (UKCC 1986) moving pre registration nurse training into the higher education sector.

The subsequent development of forensic mental health nursing in the United Kingdom was gradual, service planning and development outstripping in many respects the corresponding academic developments in all professional groups involved in forensic practice, which is the view of some authors (Grounds, Snowden and Taylor 1995 p 729).

The expansion of the forensic mental health nursing literature is now so increased that many works are in the process of re-examining, what some consider to be baseline knowledge and standardised set of skills, necessary for nurses to work within forensic settings. Collins (2000), a mere 14 years after Niskala (1986), had begun to identify competency in forensic practice. He (ibid.) has provided an overview of a range of procedures in secure settings, many of which relate to the practitioner new to the forensic environment. Collins outlines

how he considers such knowledge, and a repertoire of baseline skills, to be necessary for working in healthcare settings deemed to be secure in nature.

Collins groups these 'different' skills and knowledge, illustrating the broader, more complex understanding a forensic mental health nurse must have of;

- Security
- Detained patients
- Patients classified as suffering psychopathic disorders
- Self harm
- Violence
- Seclusion
- Multidisciplinary working
- Patients relatives and visitors
- Risk assessment and management
- Safeguarding patients rights

(From Collins 2000)

The needs of FMHN's in terms of them wishing to expand their horizons educationally are also addressed within the literature. Kettles and Robinson (2000) relate a survey conducted by themselves (Kettles and Robinson 1998) of ten secure units in Scotland and England. This study was undertaken in order to address a number of issues in forensic mental health nursing, amongst them what sort of training was required. They write of nurses, within their study group, wanting more training and education in areas related to the 'Prison Service', the Criminal Procedures Act, dangerousness and manipulative behaviours (Kettles and Robinson 2000 p 34).

The impact of forensic mental health nursing, particularly in terms of generic mental health nursing practice is noticeable in many aspects of mental health care.

The expansion of forensic and secure services was increasingly matched by expansion and development of the term 'forensic' as illustrated by Chaloner (2000);

> 'In recent years the term 'forensic' has been applied to mental health care within a range of clinical areas. From being the exclusive property of those working in secure services 'forensic' has been adopted by many mental health professionals whose role involves contact with mentally disordered offenders within or beyond in patient services. The development of forensic mental health nursing has seen the concomitant mergence of forensic psychologists, forensic social workers, forensic occupational therapists, and of course forensic psychiatrists'
>
> *(Chaloner 2000 p 2)*

Such development is mirrored in formal post registration forensic nurse education, and how it has evolved from the mid 1980's to the present. McClelland and Cutler (2001) have outlined how rapid development occurred during this period, contrasting educational developments with service and clinical developments (see Appendix One). The Joint Board of Clinical Nursing Studies (JBCNS) had generated a course during the 1980's (Course number 960) of four to six weeks, to facilitate an appreciation of the philosophy of care in secure environments. The completion of the course was awarded with a certificate of attendance.

This course displayed a;

> 'Clear developmental path in terms of syllabuses and course breadth, as compared to the earlier JBCNS course which was based on the care of the violent or potentially violent individual (course number 955).'
>
> *(McClelland and Cutler 2001 p 108)*

Further progression and advancement of English National Board (ENB) forensic course provision is outlined by both McClelland and Cutler (2001) and Chaloner (2000) when they relate how the development of the ENB 770 course (Nursing within Controlled Environments) made specific reference to developing and adapting present skill and acquiring new skills in caring for mentally disordered offenders. The ENB 770 course was openly innovative at the time (1988 onwards) in both its length (between six and nine months) and in its assessment

criteria, both summative and formative, also incorporating a clinical placement. The choice of clinical placements, particularly amongst the first courses run at Ashworth Special Hospital and Reaside Clinic MSU (Birmingham), reflected closely what Mason and Mercer (1998) referred to as the heritage of forensic practice, policing criminology and penology. Students were encouraged to complete small-scale research projects as part of the course requirement and were supported in making their own choice of subjects to study. This was a clear move to an adult centred learning approach. Interestingly students choices reflected many of the areas which Kirby and Maguire (1997) later identified as the core work of the forensic nurse: 'forensic environments, offending behaviour and crime and the forensic psychiatric nurse and examples of nursing interventions (ibid. p 395).

It would appear that the national picture of academic development in forensic nursing generally in the late 1980's and early 1990's contrasts with the picture presented of academic development in forensic practice suggested by Grounds et al (1995) earlier in this review, in that it was only then moving in to the higher education arena. Certainly the late 1980's and early 1990's were times of significant and dynamic change in nurse education in the UK. That post registration nurse education was to move entirely into the university sector can be seen as being heralded by the changes to pre registration nurse education from 1986 onwards. Project 2000 (UKCC 1986) effectively changed the status of nurses in training to that of students in a higher education establishment. Nurse registration was now awarded at diploma and degree level. Post registration courses offered at certificate level, whilst offering a foundation level introduction to a subject were viewed by some as less attractive than entering into studies at level 3 or above. Carton (1998) has gone further in specifically asking whether forensic certificate course provision met the 'challenge' facing practitioners regarding advanced knowledge and skill 'development' (ibid. p 252). Tarbuck (1994) conceptualised this problem in his influential work on the therapeutic use of security, providing a model for forensic nursing. Tarbuck (1994) set out to illustrate that a practical model for nursing patients in a secure environment was feasible, whilst at the same time indicating how any progressive model would be incompatible with a 'security world view' or 'penal model system' (Tarbuck 1994 p 555). Tarbuck outlines the importance of developing curricula within forensic nurse education, which promotes research into the skills base of forensic nursing. He provides a

useful list of what he considers to be the knowledge base for forensic nursing, which includes the following;

Forensic Psychiatric Nursing (knowledge base)

- Promotion of mental health
- Patient advocacy
- Self awareness and reflectivity
- Communication studies
- Social (interpersonal) skills
- Concepts, theories and models
- Counselling
- Psychodynamic psychotherapy
- Behavioural psychotherapy
- Social psychotherapy
- Family therapy
- Psychosexual counselling
- Victims of abuse
- Management of dangerousness

(From Tarbuck 1994 p 562)

Tarbuck clearly illustrates how he thinks that the range of therapeutic work, as well as working with victims of abuse, are core skills of the forensic psychiatric nurse. Such work reflects the importance of advancing the practice of FMHN's, and expanding their role. This need for expansion of the FMHN role needs to be placed in the context of rapid service development during the latter half of the 1980's and throughout the 1990's. It can be seen that modern Universities adapted well to such developments recognising that, with support, clinicians could develop areas of their work to enable others to acquire knowledge and skills to function effectively in areas associated with ground breaking practice.

Textbooks began to emerge reflecting a range of developments in forensic practice associated with educational development (see Morrison and Burnard 1992), culminating in a number of key publications at the end of the 1990's and early into the new century (see Tarbuck et al 1999, Mercer et al 2000, Chaloner and Coffey 2000, Robinson and Kettles 2000 and McClelland et al 2001). Specific academic development was slower, but began to emerge in a number of original research articles and the development of a range of higher educational courses. Both McClelland and Cutler (2001 p 110) (see Appendix One) and Chaloner (2000 p14) illustrate how Universities in London, Birmingham and Liverpool all developed innovative developmental multidisciplinary educational courses, very often in collaboration with medium and maximum secure clinical services. Such moves were clearly indicative of the need to encapsulate the rapid development and innovative service delivery in forensic practice. McClelland and Cutler (2001 p 110) illustrate one clear example of such work when the providers of medium secure services in Birmingham collaborated with Birmingham University. The collaboration developed a forensic nursing pathway, incorporating the ENB 770 course and the Higher Award, within a post experience Diploma and Masters in Science course (P.Dip, MSc).

The nature of specialist practice was integral to the curriculum development of this course, and can be seen as encouraging the generation of original research by:

> 'contributing significantly to the forensic nursing knowledge base through the completion of a research dissertation in year two'
>
> *(McClelland and Cutler 2001 p 110)*

This course, along with many others at the time, broadened the appeal of Forensic Mental Health education by ensuring multi professional engagement in terms of student makeup, teaching and course content. Chaloner (2000) provides clear examples of this when he outlines theoretical content of a Forensic Degree Programme at City University and St Bartholomew, London, from 1997/98 as follows;.

- forensic mental health theory

- the history and aims of Forensic Mental Health Care
- assessing and managing risk and danger
- models of interdisciplinary and inter agency care
- dual diagnosis in forensic settings
- issues of control and power in forensic settings
- dealing with and supporting victims
- concepts of professional and therapeutic relationships

(From Chaloner 2000 p 12)

Chaloner (2000) further illustrates how this latter course, which was part of a forensic nursing degree was developing into a multi professional programme, and provides an example of such a course at St George's Hospital Medical School from 1998, covering modules with titles such as; Violence and Dangerousness, Ethics and Forensic Mental Health Care and Forensic Psychotherapy (from Chaloner 2000 p 14). The focus of all of this provision was to expand the understanding and knowledge base of forensic mental health practitioners into areas they would likely encounter in the challenging and developing arena of forensic practice. McClelland and Cutler (2001) illustrate how the course content of the PDip/MSc programme at Birmingham University expanded this area of study further, to a range felt appropriate to a more comprehensive study of health science. The Birmingham University course included modules covering research methods, health and illness in contemporary society, bio/psycho/medical sciences underpinning the students individual clinical pathway, specialist practice clinical fieldwork, clinical decision making skills and a practice innovation proposal (see McClelland and Cutler 2001 p 111). The breadth of such course content, and the aspirations to true multiprofessional course provision is clear evidence of academia striving to achieve, and match, the same level of service development witnessed in forensic mental health care, particularly in the period from the mid 1980's to the present.

The forensic mental health nursing literature is developing, but perhaps cannot yet be considered strong. The research literature is certainly weaker than the review and practice

literature, but this too is developing as Peternelj-Taylor (2000) illustrates in relation to the forensic nursing research position in Canada;

> ' It is safe to assert that research in forensic nursing is largely underdeveloped even though a gold mine of opportunity exists.'
>
> *(Peternelj-Taylor 2000 p 210)*

The situation in the UK is not overly dissimilar to that of Canada. There is a wide ranging British literature focusing on anecdotal, review and practice aspects of forensic mental health nursing (Kitchener et al 1992, Morrison and Burnard 1992, Burrow 1993a, Burrow 1993b, Mason and Mercer 1996, McCann 1996, Robinson and Reed 1996, Kirby and Maguire 1997). Much of the work of these authors (and others) is evidence based, sometimes utilising very strong and pioneering methodologies. However, despite such work, and taking into account the growth of educational provision for forensic mental health nurses over the period 1985 - 2000, previously documented within this work, Storey and Dale (1999) in their scoping study of nursing in secure environments, paint a disappointing picture. Their landmark document 'Nursing in Secure Environments' was a scoping study conducted on behalf of the UKCC by the Faculty of Health, University of Central Lancashire. The foreword to this document by Alison Norman, the then UKCC President, identified secure environments as the most challenging arenas in which any registered nurse can work. The report aimed to provide a comprehensive picture of educational, occupational and practice expectations of nurses in such environments. Storey and Dale (1999) in their introduction to the work outline how their objectives, amongst many, included a description of the competencies of nurses working in secure environments, to assess whether nurses interventions were evidence based and to review the effectiveness of preparation currently given to nurses working in secure environments (ibid. p 9). Unfortunately the encouraging development in educational preparation for post registration nurses outlined earlier in this review is not borne out by this scoping exercise.

The findings of the scoping exercise, particularly those related to the post registration education provision and continuing professional development (CPD) of staff clearly identify the following:

- a range of different skill bases (ibid. p 94)
- qualifications in the prison health service staff group not reflecting the needs of the population (ibid. p 94)
- 60% of staff in secure healthcare environments having no post registration qualifications (ibid. p 95)
- access to post registration education being a problem despite a wide range of programme availability (ibid. p 96)
- study leave focusing on mandatory training rather than C.P.D. (ibid. p 96)
- many Nurses believed that clinical supervision is not part of their employing organisations culture (ibid. p 99)
- the ways in which individuals are supported in CPD is ad hoc, some practitioners receive a great deal of development whilst others receive little or none (ibid. p 104)
- limited evidence to state whether any post registration courses improve competency for working in secure environments, the only examples cited of competence being enhanced were in relation to the thorn-cognitive behaviour therapies and psychosocial interventions programme (ibid. p 104)

(From Storey and Dale 1999)

This scoping exercise was extensive, interviewing thirty five staff from a wide range of areas involved in secure care across the UK, holding 20 focus groups across the UK, extensively reviewing the literature in the area of forensic care and distributing questionnaires to sixty five education providers across the UK. A critique could perhaps be related to the small number of medium secure care environments included in the work, particularly in light of comments previously identified in this review by Gunn and Taylor (1995) that these centres are the focus of forensic psychiatry development. Allied to this there appears to be only slight reference to the Academic and Research base of a range of centres which were the focus of this scoping

exercise, many of which are accessible to a wide range of staff working in secure environments. The work is broad however, and captures a picture of inadequate post registration forensic educational preparation at the end of the 1990's. There is indeed a dearth of literature examining uptake of post registration courses such as that detailed earlier in this review. The development of innovative curricula does not appear to equate with uptake of course places. It is clear that more work is required to address problems of uptake outlined by Storey and Dale (1999). This researchers experience of a number of post registration forensic nurse education courses is that the student number is consistently small, the largest post-registration student cohort over a ten year experience of academia numbering ten. Kettles et al (2001) support this on a global scale, when examining perceptions of forensic nursing in 8 countries. This work found that in a sample of 492 health care staff in secure hospital settings (the majority of whom were nurses) there was a general feeling that nurses were being asked to become more expert without the benefit of training and education. Respondents both within a survey, and in focus groups indicated clear dissatisfaction with educational support and opportunities in forensic settings;

> 'all nurses clearly indicated that training and education is patchy and poorly done'
>
> *(Kettles et al 2001 p 34)*

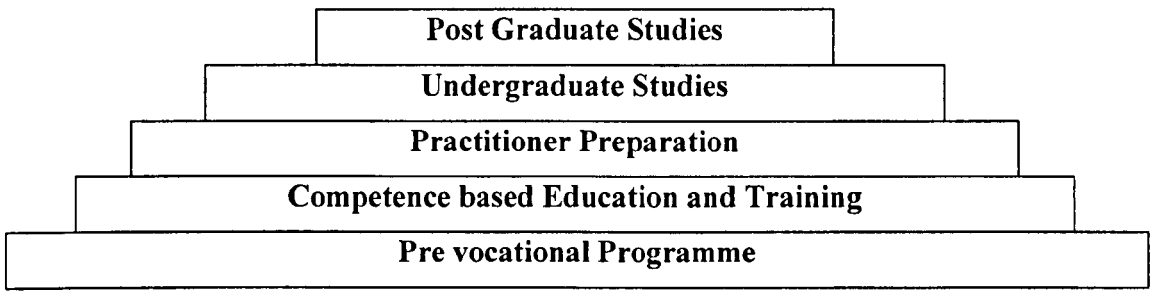
If the forensic mental health service is to address the theory practice gap among nurses and others in areas such as victimology, enhancing the maltreatment knowledge base and assessment of risk, then it is clear that more focused strategies need to be developed.

Beacock (1994) seven years before Kettles et al (2001) in identifying an education and practice gap in forensic practice had warned of the importance of such educational strategies and structures;

> 'Without a structure upon which to base strategic educational planning the task will not be successfully completed'
>
> *(Beacock 1994 p 550)*

Beacock (1994) outlined a clear development strategy for developing staff in secure forensic settings, illustrating how the further development of the knowledge base for forensic care would entail a higher level of achievement provided by study at Masters level. This would enable the Clinician to engage in the necessary level of research and analysis within the specialty (Beacock 1994 p 549).

Beacock proposes a five-tier model encompassing the following:



(Beacock 1994 p 549)

This model supports forensic related content from the point of practitioner preparation. Interestingly the concepts of specialist, advanced and expert practice beyond the area of forensic mental health care (encompassing all nursing practice), came to be the focus of specific legislation in the UK in the late 1990's, which resulted in the establishment of the nurse consultant role.

The landmark document 'Making a Difference' (DOH 1999a) was key in taking forward a changed view of the nursing career framework in the UK. Yvonne Moores (the then Chief Nursing Officer) cited in an article by Stephen (1999) in the Nursing Standard Journal anticipated that Nurse Consultants would;

> 'Achieve three Policy Objectives, to improve clinical outcomes for individual patients, to provide a clinical career pathway for nurses and strengthen nurse clinical leadership.'

(Stephen 1999 p 4)

Ms Moore's went further in this article to illustrate how she believed a major part of the nurse consultant's job to be about high-level clinical nursing practice and direct patient care. There was a clear inference in the press briefing by Ms Moores that Nurse Consultants would be educated to Masters level. The rationale for the creation of such posts in the UK can be seen in the influential work of people such as Kim Manley, the then head of practice development at the Royal College of Nursing Institute. Parish (2000) indicates how it was Manley who began the research that led to the establishment of consultant nurse posts in the UK. Interviewing Manley for the Nursing Standard, Parish (ibid.) reveals how she believes nurse consultant's to be on the top rung of the clinical career ladder, steeped in practice. Further to this she illustrates the four main components of the work of the Consultant Nurse;

> ' First the consultant nurse must be an expert in his or her field, and they must be expert in creating a learning environment. Nursing is not just about interventions, it involves co-ordination continuity and creating the context of care. The third area is research. A consultant in medicine might be an expert researcher in a particular methodology. But a consultant in nursing because of concerns with culture and context, would expect to be an expert in a number of methodologies. The fourth area is a consultant. This is not just about giving advice. The most important part of consultancy is helping nurses become self sufficient in their own problem solving.'
>
> *(Kim Manley cited in Parish 2000 p 15)*

The NHS Executive (1999) moved Manley's theory concerning the role of the Consultant nurse into a concise set of inter-related functions;

- Expert Practice;
- Professional leadership and consultancy;
- Education and Training Practice;
- Service Development;
- Research and Evaluation;

(NHS Executive 1999)

Cox (2000) illustrates how the nurse consultant must be based in practice for at least 50% of their time. She also illustrates how they would be;

> 'expected to exercise a high degree of professional autonomy and make critical clinical decisions.'
>
> *(Cox 2000 p 48)*

The impetus to appoint Nurse Consultants in hospital Trusts grew rapidly over the latter half of 1999 and throughout 2000. Hospital Trusts were required to make regional submissions concerning appointments they wished to make, for the purpose of approval. The development of the 'Making a Difference' document in 1999, strengthening the contribution of Nurse Midwives and Health Visitors to healthcare, ran alongside the publication (in the same year) of the National Service Framework for Mental Health, (DOH 1999b). The almost simultaneous publication of these documents legislating significant change and development in mental health care in the UK is perhaps evidence of 'joined up thinking'. Certainly the influence of these new nursing posts, and the potential impact they could have can be seen in an editorial by Appleby (2000) in the British Journal of Psychiatry.

Louis Appleby, the National Director for Mental Health in England at the time, clearly indicated where he felt nurse consultant roles might be developed;

> 'the treatment of dual diagnosis patients, acute triage and long term continuing care'
>
> *(Appleby 2000 p 291)*

The opportunities and developments associated with the establishment of Nurse Consultants in the late 1990's in the UK was welcome. However, there were some negative aspects to this phenomenon, which began to be identified quite quickly in the nursing journals and literature. Cox (2000) has indicated how the role of the advanced nurse practitioner and clinical nurse specialist had large areas of overlap with that of the nurse consultant role. Many UK hospital trusts were inconsistent in terms of demanding a wide variety of academic qualifications and

experience, as well as developing the posts in isolation of each other (Lipley 2000). Lipley (2001) reports on a new recruitment drive to fill nurse consultant posts, highlighting how thirty per cent of approved posts were still vacant due to a lack of suitable candidates. He cited John Lancaster, the NHS Executive National Leadership Project Coordinator who commented on this shortfall:

> 'it is evident that the pool of possible Nurse Consultants is rapidly becoming a puddle'
>
> *(John Lancaster cited by Lipley 2001 p 7)*

The requirement that aspiring Nurse Consultants be educated to Masters level (see Making a Difference DOH 1999) would appear to have been one of the main stumbling blocks to appointment. This coupled with a lack of preparedness and few suitable candidates (see Lipley 2001) further confounded recruitment.

Clearly the rationale for establishing Nurse Consultants, maintenance of clinical contact, ensuring a developmental career path, and promoting expertise in nursing practice, whilst worthy, may have been somewhat ahead of the requisite academic development, at least in the UK. The lack of preparedness alluded to by Lipley (2001) had been addressed in developed countries outside of the UK as early as 1974 in New Zealand, and 1984 in Australia (see Greenwood 2000).

Greenwood (2000) relates that these early moves in New Zealand and Australia testify to the growing dissatisfaction with previous Nightingale apprenticeship models of nurse education. She refers to nurses educated under the apprenticeship model as 'doers' rather than 'thinkers' (Greenwood 2000 p 18).

New forms of educational preparation (Diploma /Degree) are assumed to be the best form of education to address the challenges presented by modern healthcare;

> 'All pre registration programmes in westernised democracies now aim to produce nurses who are beginning practitioners in nursing'
>
> *(Greenwood 2000 p 19)*

Greenwoods observation echoes Beacock's (1994) model suggesting forensic related content being introduced at the point of practitioner preparation. The pre-registration experience of diploma and degree education in the UK is still relatively young, and this level of practitioner preparation, particularly in emergent specialties such as Forensic Mental Health Nursing is also relatively young. Storey and Dale (1999) as illustrated earlier, found that continuing professional development in post basic forensic education and training was still ad hoc in the UK. Such observations combined with arguments that specialist nurses are the nurses who will lead and foster the future practice of nursing (Appel and Malcolm 1998) perhaps explain why the establishment of Nurse Consultants in the UK was encountering difficulty, particularly in being able to fill available positions. Because of the ad hoc approach to C.P.D. of forensic mental health nursing staff over the period 1985–2000, there are perhaps not enough appropriately experienced, and qualified, forensic mental health nurses to assume the newly created positions. Appel and Malcolm (1998) clearly indicate that attention to C.P.D. is key to developing expertise in any area of practice;

> 'nurses who maintain their competence are valuable as clinical experts in areas of specialist practice'
>
> *(Appel and Malcolm 1998 p 150)*

Interestingly Appel and Malcolm are writing from an Australian perspective, one which has the benefit of a much longer period of pre registration engagement with higher education than their UK counterparts.

The gradual development of Nurse Consultants in the U.K. is perhaps the key to the way this role may be developed in the future. Chalder and Nolan (2001) in an early evaluation of the

role of the forensic nurse consultant in the U.K. expressed some misgivings about the ways in which other team members perceived the role. In response to a brief questionnaire distributed to a multi-disciplinary group of staff (almost 50% of which were nurses) respondents ranked 'expert practice' as 5th in a list of six areas, when asked what they thought the role of the forensic nurse consultant to be. Similarly when asked to rank advantages of the role, being seen as the 'local expert' ranked 5th in a list of seven areas. This was a small-scale study with only 17 respondents, thus it is difficult to generalise the findings. However the work appears to suggest that a range of professionals did not consider expertise, or expert practice to be a key feature of the role. Interestingly Chalder and Nolan (2001) contrast the American experience of nurse consultant development as more positive than the U.K. picture;

> 'whilst the post of nurse consultant is still being developed in the U.K. it has existed for at least two decades in North America'
>
> *(Chalder and Nolan 2001 p 24)*

Despite this supposedly contrasting observation, and the observations of Appel and Malcolm (1998) discussed earlier (re the Australian experience), it would appear that the global situation, as described by Kettles et al (2001) is not as different to the U.K. as is suggested. Kettles et al (2001), briefly mentioned earlier in this review, addresses the dearth of work related to competency or fitness to practice, post registration/advanced practice and forensic nursing. The article provides an international take on the situation, and whilst recognising the wide range of forensic course provision in the U.S.A, is critical of the lack of coordination and wide scope of definition of what constitutes forensic nursing. The study utilised a combination of focus groups and survey across eight countries, England, U.S.A, Canada, Scotland, Norway, and Germany, the Netherlands and Australia. The researchers noted few differences in the responses to questions across all 8 countries. The study infers that advanced practice in forensic nursing is somewhat under developed largely due to the poor forensic educational provision at both under and postgraduate levels. This in turn is perhaps suggestive of a poor career pathway for aspiring forensic mental health nurses who wish to enter into study associated with advanced practice.

The authors illustrate that the respondents are acutely aware of how they compare to their colleagues in other disciplines;

> 'other disciplines such as psychology and psychiatry have unmistakable post graduate education and career pathways to specialise in forensic care. However for forensic nurse education this kind of clear pathway is not immediately evident.'
>
> *(Kettles et al 2001 p 30)*

The authors maintain that the lack of appropriate preparation, training and education, and the ways in which nurses in forensic areas compare unfavorably to their colleagues runs throughout the study;

> 'from the perspective of the United Kingdom sample medical forensic education versus nursing forensic education was viewed as worlds apart, with the medical education being seen as far superior to that received by nurses.'
>
> *(Kettles et al 2001 p 35)*

The authors are critical of their own method, illustrating how focus groups tend to attract only interested parties, and of how convenience samples limit generalisation to larger populations. A further limitation of this work relates to hermeneutics (language and its meanings) not being addressed in any way. This is perhaps important when such work endeavors to examine a wide range of diverse cultures, and secure environments and settings within these cultures. Despite these limitations the work is perhaps illustrative of the perceived disparity in education and training in forensic health care between nurses and other professional groups working in this area.

2.3 Epidemiology/Secure Hospital Populations

As previously indicated within this review, secure hospital development has 'mushroomed' in the last two decades. Despite this rapid rate of development however, such changes and cultural shifts can be viewed as reactive as opposed to proactive. Key reports of inquiry

(DHSS 1980, DOH 1992, Fallon 1999) paint a disappointing picture of 'therapeutic' services, management, and staffing in the Special Hospitals in the UK. It could therefore be argued that inquiry driven critique, which in turn leads to service change and service development does not lend itself to strategic cultural shifts and service development in secure hospital provision.

Badger et al (1999) illustrate this well in their systematic review of the epidemiology of mentally disordered offenders. Despite the focus of the work being on the UK Special Hospital population, this is an ambitious work, which clearly illustrates the often confounding problems associated with undertaking such an epidemiological survey. The authors (ibid.) write;

> 'establishing the prevalence of a disorder is the core goal of epidemiology'
>
> *(Badger et al 1999 p 17)*

If this is actually the case then the need to identify the numbers of patients within a service is necessary. The authors (ibid) indicate further confusion in their estimation that at least half of the patients resident in Special Hospitals do not require maximum-security hospital residence. Hence any estimation of prevalence must take such factors into consideration. There is a further confounding factor related to the base offender population:

> 'there is no British study to adequately describe the epidemiology of mentally disordered offenders in the general population'
>
> *(Badger et al 1999 p 11)*

Coupled with the fact that there is a difficulty in finding a specific definition of 'mentally disordered offender' in the literature (Peay 1996, Bailey 1996) there is a need within epidemiological studies to address the following;

> 'To identify risk factors for being a 'mentally disordered offender' (however defined) it is necessary to have data on potential risk factors, particularly demographic variables on the mentally disordered offender population being studied, and also an underlying base population. Risk factors for having a mental disorder within a population of offenders will require data on the base offender population, and on the sub population of mentally disordered offenders'
>
> *(Badger et al 1999 p 13)*

Therefore we can see that there are problems associated with estimations of service need and requirement because of associated problems in estimating the prevalence of mentally disordered offending. A further linked issue is one of definitional interpretations of violence (a key focus of this work, and much of forensic psychiatry nursing/research) and offending behaviour. There is clearly a difficulty in drawing conclusions due to the range of definitions of violence, (Badger et al 1999), and the 'over inclusiveness' of definitions of the 'mentally disordered offender' (Farrar 1996).

2.4 Characteristics of Special Hospital and Medium Secure Hospital Populations

Despite the difficulty in establishing prevalence of mentally disordered offending there are some studies which have been conducted which reveal descriptive data on the demographic characteristics of clients resident in maximum and medium secure UK hospitals, within the last decade. Such data is useful insofar as to make comparison to research data in this study, but also in the revealing picture of a split in gender, ethnicity, diagnosis, offending and age. Some of the more recent data, particularly in relation to medium secure services can be considered as perhaps more 'strategic', in approach in terms of its aims to develop specific services, as opposed to 'reactive' development as previously reported in this work.

A recent Department of Health commissioned report (DoH 2000/2001) on a survey of forensic care networks in England and Wales is pertinent to this study. This survey of medium secure units examined both NHS facilities and Independent sector facilities. Further to this it provided descriptive data for both services for Adults with a mental illness as well as those with Learning Disabilities. For the purposes of this review I will focus on the NHS facilities surveyed, for adults with a mental illness.

In terms of those numbers in residence in the Special Hospitals (Ashworth, Broadmoor and Rampton) in England, Grounds et al (1995) illustrates well the close relationship between maximum and medium secure hospitals. They relate the overall decline in admissions to the special hospitals over the last three decades, particularly between 1973 and 1982. The fact that medium secure units started to open in the mid 1970's is not lost, particularly in their observation that;

> 'it maybe coincidence but the medium secure units started to open in the mid 1970's, and were reaching their capacity by the mid 1980's, when the special hospitals population started to rise again'
>
> *(Grounds et al 1995 p 700)*

The numbers resident in special hospitals are reported within this work as falling below a number of 1700 in 1990, from a number of above 2300 in 1960. This decline would appear to be directly related to the establishment of medium secure facilities. The number of NHS medium secure unit beds for England and Wales in the year 2000 is reported by the Department of Health as 1341 (DOH 2000/2001 p 2). England had 1283 beds, and Wales had 58 medium secure beds. Interestingly the growth of the independent sector in this specialized area of care appears to have been significant, and the report indicates that the combined number of medium secure beds available in the independent sector (England and Wales) is 721. Certainly within England the independent sector has 34% of the available supply of medium secure beds.

The survey also indicates the wide range of distribution;

> 'The England beds were provided within 27 NHS facilities and 11 independent facilities, located within 8 English regions. The Wales beds were provided in 2 NHS facilities and 1 independent sector facility'
>
> *(DOH 2000/2001 p 2)*

This figure can be considered as an accurate picture of medium secure provision. The survey followed on from the review of high security establishments following the Fallon inquiry (1999) into Ashworth hospital's personality disorder services. The survey set out to examine a range of areas, including capacity and capability of medium secure provision, the relationship of medium secure unit's to other parts of the forensic network, and planned and anticipated development for the future. Again, however it is worth remembering that it was only 8 years prior to this report in 1992 that the DOH and Home Office had undertaken a major comprehensive review of health and social services for mentally disordered offenders known as the 'Reed Review' (DOH and Home Office 1992). The medium secure unit review can therefore also be seen as a 'reactive' review following on, as it self reports, from the Fallon inquiry. The approach of the medium secure unit review however does appear to have been very comprehensive, recognising that 100% response rate was vital. As with the earlier work of Badger et al (1999) the survey relates how forensic services themselves are not well defined, even insofar as to which services are designated as 'medium secure'. To this end the survey organisers (AFH Partnerships) utilised a lead co-coordinator to complete the survey in Wales, and in the eight English regions.

With regard to gender in secure hospitals it is commonly accepted that there are a high proportion of males to females in such care. The percentage of males in the special hospitals has been given as 83%, (Taylor et al 1998), and the percentage of females in medium secure care as 13.8.(DOH 2000/2001). Within the Special Hospital population there is an ethnic split, of 81% white, 19% non-white for males, and 90% white, 10% non-white for females.(Taylor et al 1998). Similar figures are reported for medium secure care with 83% of the NHS medium secure unit population in six of the eight English and Wales regions falling

within the white ethnic group category (DOH 2000/2001). This latter survey however, indicates that two regions of England had significantly different profiles;

> 'London had only 41.7% of its population described as white ethnic. The West Midlands had only 58.2% of its population described as white ethnic'
>
> *(DOH 2000/2001 p 3)*

Clearly any research findings related to ethnicity in these regions would have to take such considerations into account. This medium secure unit survey provides further breakdown of ethnicity as follows;

> NHS Patients (England)
> 72.4% of in-patients fell within white ethnic group
> 20.4% of in-patients fell within Afro-Caribbean ethnic group
> 7.0% fell within the Asian ethnic group
> 2.2% were of mixed race
> Ethnicity (Wales)
> The majority of inpatients, 92%, fell within the 'white ethnic group'
>
> *(DOH 2000/2001 p 28/29)*

Primary diagnosis in the 3 Special Hospitals (1994 study) is indicated as follows; mental illness 66%, psychopathic disorder 25% and mental impairment at 8% (Taylor et al 1998).

A breakdown of primary diagnosis within the medium secure units is as follows;

> 92.4%- Mental Illness
> 7.3%- Psychopathy /Personality Disorder
> 0.3%- Learning Disability
> 8.5%- Dual Diagnosis
>
> *(DOH 2000/2001 p 22)*

It is further reported that in terms of diagnostic breakdown the medium secure services in Wales reflected similar profiles to English figures (ibid. p22).

In terms of offending behaviour the literature associated with Special Hospitals is comprehensive in terms of detail. The index offence can be defined as 'the most serious offence leading to admission' (Badger et al 1999). Within the Special Hospital population a number of studies reflect how violence against the person is the most predominant index offence in special hospital populations.

Table 1

Proportion of Patients with an Index Offence of Violence against the Person

Index offence of Violence against the person (% of Special Hospital population)

Taylor et al 1998	63%	(61%, 65%)
Taylor (1997) (figures for 1994)	65%	(62%, 68%) for men
	41%	(35%, 47%) for women
Shaw et al (1994)	49%	(40%, 58%)
Murray et al (1994)	69%	(60%, 78%)
Maden et al (1993)	69%	(64%, 74%)
Huws and Shubsachs (1993)	50%	(49%, 51%)
Naismith and Coldwell (1990)	73%	(65%, 81%)

Figures in parentheses represent 95% confidence intervals.

(Badger et al 1999 p 56)

The range of studies discussed in this work indicates that within Special Hospital populations;

- Index offences of women are less likely to involve violence than men's offending (Taylor 1997)
- Men with Schizophrenia are more likely to have an index offence of homicide than men with a diagnosis of Personality Disorder. (Naismith and Coldwell 1990)
- Men with Personality Disorder are more likely than those with Schizophrenia to have an index offence which is a sexual offence (Naismith and Coldwell 1990)

(Badger et al 1999 ps 57, 58)

The referral and admission criteria of the medium secure hospitals is so different to that of the Special Hospitals as to make epidemiological review of offending behaviour more difficult.

The range of offending and admission without offence is so wide that the literature outlining offending prevalence in these units is more problematic. The medium secure unit survey indicates the sources of admission in NHS medium secure facilities;

> 'Men- over half were from prison
> 13% from high secure hospitals
> 12% from acute wards (ICU's)
> Women- Over half from prison
> 18.8% from high secure hospitals'
>
> *(DOH 2000/2001 p 32)*

With regard to 'Age', the longer periods of in-patient care in the Special Hospitals perhaps create the opportunity to record data such as the mean age of women being 37 years, and men at 39 years, with a range of 17-88 years (Taylor et al 1998). Surveys of hospitals where individuals are resident for shorter periods of time merely indicate an age range of 18-65 years, with more common usage of services between 18 years and 60 years, with a marked reduction in services used by those individuals aged 66 years plus (DOH 2000/2001). The medium secure in- patient stay is certainly shorter than the average Special Hospital in-patient stay;

> 'Patients tend to spend a long time in a Special Hospital. The average length of stay is about eight and a half years, varying according to the class of disorder'
>
> *(Taylor et al 1995 p 698)*

Such a length of stay in special hospitals clearly creates a situation where fine detail concerning client characteristics can be researched, compared with the average length of stay of less than 2 years in a medium secure unit (DOH 2000/2001).

Despite the fact that there are many planned developments within medium secure services over the next decade women's services, long term medium secure provision, personality disorder services and a general increase in bed numbers there are concerns for the future also (DOH 2000/2001). Staffing issues appear to be of concern (ibid.), similar issues having been addressed within the wider NHS through a range of legislation over the last five years, but of concern nevertheless. The report (ibid.) indicates that 85.2% of the NHS facilities were not fully staffed, and of how 69.5% of these units were experiencing long term recruitment problems. 74% of the 23 NHS facilities responding to questions concerning vacancies had nursing staff vacancies. Whilst this study is cognisant of the fact that the therapeutic activity of a hospital is not wholly reliant on specific groups of staff such as Doctors and Nurses (Doctors also reporting shortages in answer to the vacancy question), limitations on what the service can provide are often the result.

Those involved in the survey were asked to comment on such limitations, comments linked to such vacancies and shortages were as follows;

- 'therapeutic actions have been curtailed'
- 'they (the shortages) are having detrimental effects on quality and continuity of care'
- 'we are not providing the full range of treatments'
- 'the shortages have an adverse effect on therapeutic input'

(DOH 2000/2001 p 58)

Such findings within the literature clearly indicate the need for progressive change, not only to enable cultural shift in service development, but also in areas of recruitment, retention and staffing, and the attendant management and care strategies required to address future need.

2.5 Childhood and Adolescent Abuse: What Do We Mean?

Almost 40 years ago, in the American Journal of Psychiatry Curtis (1963) questioning whether violence breeds violence, looked to the possibility of abused and neglected children becoming:

> 'tomorrow's murderers and perpetrators of other crimes of violence, if they survive'
>
> *(Curtis 1963 p 386)*

Certainly this identification of the concept of violence being transmitted from one generation to another appears to have been a phenomenon, which emerged from the early 1960's onward. Brierè and Runtz writing in 1988 indicate how mental health professionals have only formally acknowledged maltreatment of children since 1962 (Brierè and Runtz 1988a). They (ibid. p 33) trace the development of the study and research in this area from the ground breaking work of Kempe et al (1962), who coined the term 'The battered child syndrome', effectively bringing the subject of severe physical abuse to the attention of the American public.

Certainly, within the western world over the last 25 years there appears to be a raised public awareness and understanding of childhood maltreatment in its various forms. In many ways this can best be viewed as a raised 'popular' awareness. Concepts such as posttraumatic stress disorder have found their way into the popular media such as daytime television programmes in both the United States and the United Kingdom, revealing a wide range of child maltreatment behaviours, both from the perpetrators and victims' perspective. Therefore we can see that both the popular awareness of child maltreatment and the research literature have both grown within the same period.

This growth in awareness therefore has led to an increase in the identification of various forms of maltreatment. The development of the knowledge base in this area has expanded so rapidly as to include a much larger area of child maltreatment than Kempe's 'battered child syndrome', a term which by 1980 has been replaced by 'child abuse' (see Corby 1993).

Cultural forces and social shifts clearly have an impact on what is considered to be, or recorded as 'child abuse':

> 'child abuse is a socially defined construct, it is a product of a particular culture and context, not an absolute unchanging phenomenon'
>
> *(Corby 1993 p 39)*

Thus in attempting to describe the nature and size of the phenomena of child abuse many researchers are torn between utilising the official statistics, from the government departments, and the figures from the research base, which may be examining neglected populations such as those in clinical or prison settings. Add to this confusion the fact that a wide range of often conflicting definitions of abuse are used by the government departments and researchers alike, then the methodological difficulty in researching this area begins to become apparent. This in turn makes associated work, such as examination of causation, consequences of abuse, and the efficacy of interventions that much more difficult, confounded further by the presence of mental disorder amongst clinical populations. Whilst there is a relatively strong literature indicating support for an intergenerational cycle of violence, where abused children become abusers and victims of violence become violent victimizers (see Spatz Widom 1989 a), there is also an equally strong critique of the research in this area:

> 'much of the research in this area is based on designs weakened by questionable accuracy of information owing to the retrospective nature of the data, or to reliance on second hand information (e.g. parental reports) rather than on directly observed or validated behaviours. Often there is no medical or direct evidence of the severity, frequency or chronicity of the abuse'
>
> *(Spatz Widom 1989b p 5)*

It is dangerous to assume that abuse leads to abuse or violence begets violence, in a way, which is not mediated by other variables. Factors such as the severity of maltreatment, the chronicity and frequency, as well as the type of abuse suffered, and a wide range of other contextual social and psychological factors are all important in assessment intervention and prevention of adverse consequences of abuse experienced in childhood and adolescence. This

section of the literature review will examine many of these concepts, as well as examining the clinician's ability and comfort in engaging with this patient group.

The ways in which clinicians, define concepts such as aggression, violence and criminal violence, will underpin the view of both the abuse suffered, and offending behaviour exhibited, in adults who may have been abused in childhood/adolescence. All such terms are heavily value laden, and may reflect the values, biases and attributes of the definer or observer (Blackburn 1993, Browne and Herbert 1997). In cases of child abuse it is often difficult to generate agreement as to what constitutes abusive and 'normal' violence. Gelles and Cornell (1990), for instance, attempted to break down this distinction by defining 'normal' violence as slaps, pushes, shoves and spankings, which are considered common place and acceptable in family arguments. Conversely they defined punches, kicks, bites, choking, scaldings, beatings, stabbings and shootings as acts of abusive violence, (Gelles and Cornell 1990 cited in Browne and Herbert 1997 p 3). If we view violence as being on a continuum of aggressive behaviour then the Oxford Dictionary definition: 'of great and impetuous force, vehement, intense, illegal use of force' (Oxford dictionary 1960), has a certain resonance with the explosive nature of behaviour often associated with a violent act. However it is worth remembering the wide range of behaviours which are considered harmful or injurious; physical violence, verbal derogation or passive obstruction, among the range (see Blackburn et al 1995). Archer and Browne (1989) have proposed a useful definition, which is sufficiently broad so as to contextualise the violence to both bodily injury and restriction of freedom:

> 'the exercise of physical force, so as to injure or damage persons or property; otherwise to treat or use persons property in a way that causes bodily injury and forcibly interferes with personal freedom'
>
> *(Archer and Browne 1989 pp 10-11)*

Further work has broken down, or dichotomized, violence within the family, into 'active' and 'passive' forms, recognising that whilst passive violence (or neglect) does not involve physical force it can cause psychological and physical injury, dependent upon the circumstance.

Browne and Herbert (1997) illustrate this two-way classification of violence, providing examples of major forms of violence in an adaptation of their previous work:

Table 2: Two Way Classification of Violence

	Physical Violence	**Psychological Violence**	**Sexual Violence**
Active Abuse	Non accidental injury Forced coercion and, restraint	Intimidation Emotional abuse Material abuse	Incest Assault and rape
Passive Neglect	Poor healthcare Physical neglect	Lack of affection Emotional neglect Material neglect	Failure to protect Prostitution

(Browne and Herbert 1997 p 9)

Thus, with more specific definitions, can we begin to examine how we can further define abuse or maltreatment, terms often used interchangeably within the literature.

Both clinical and public attention was more focused upon the phenomena of child abuse following the landmark publication of Kempe et al's (1962) work examining what came to be known as 'the battered child syndrome'. This was a key work, examining as it did the biomedical signs and symptoms present in young children who had been severely abused. The detail and definition afforded to the syndrome described by the authors (ibid.) was such that many recognise that whilst concepts and definitions change over time, the abuse described by Kempe and his colleagues would not be sanctioned in any society (Corby 1993 p 40).

However Corby (1993) also recognises that child abuse itself is a socially defined construct and is a fluid and changing phenomenon:

> 'what is considered to be abusive in a society alters over time'
>
> *(Corby 1993 p 39)*

This can be seen clearly in a research piece from the last half of the 1990's where neglect, as a type of abuse suffered, is operationally defined thus:

> 'neglect cases reflecting a judgement that the parents deficiencies in child care were beyond those found acceptable by community and professional standards at the time'
>
> *(Weiler and Widom 1996 p 256)*

The flexibility in how 'neglect' is defined is dependent upon the chronological time period in which the research takes place. This latter research however at least makes reference to this area, acknowledgement in itself being a strong point of the work. Even the landmark work by Kempe and his colleagues from 1962 has been criticised, on the basis of his definitions of childhood abuse being primarily based on medical evidence, thus only focusing upon the physical aspects of the harm and abuse (see Daveson 1982).

It would appear that the decade in which a specific piece of research was undertaken will strongly influence those who are defining abuse. Corby (1993) illustrates how work, which has a strong clinical perspective, is likely to be concerned with the individual, and thus exclusive in nature (see Kempe et al 1962), whereas a sociological view (typified by Gil 1975) will likely have a more inclusive approach to defining abuse.

Browne takes this further in recognising how three major forms of child maltreatment were identified, as each evolved and emerged as a recognised social problem, over three decades:

> 'firstly physical abuse (e.g. Kempe et al 1962) then sexual abuse (e.g. Finklehor 1979) and finally psychological or emotional maltreatment (e.g. Garbarino and Gillam 1980)'
>
> *(Browne 1988 p 15)*

From the early 1980's onward, a growth in the range of operational definitions of abuse, other than physical, has led to allied growth in work related to other types of abuse such as sexual abuse and non organic failure to thrive (see Browne 1988, Corby 1993). The complexity of child abuse as a phenomenon is borne out by the wide range of activity, which constitutes 'abusive' behaviour. This range can include physically inflicted injuries, neglect, sexual abuse, and emotional abuse without visible injuries (Creighton 1988). The advantages of developing classifications, definitions and descriptions are obvious in terms of focusing clinical work, and subsequent interventions. However in research terms the recognition that various forms of maltreatment will co-exist, and further that the severity and frequency of maltreatment will shift through dimensions of physical abuse to sexual abuse and psychological abuse can be a major methodological problem (see Browne 1997 pp 12-13). Browne and Herbert (1997) cite Crittenden (1988) in reporting abuse and neglect being present in 23% of reported cases, and Finklehor and Baron (1986) as finding that 33% of sexually abused children have also been physically abused by their parents (see Browne and Herbert 1997 p 11).

We have briefly discussed the role of the 'definer' and how their bias and focus may determine the definition chosen, i.e. clinical or sociological perspectives. However it is clear that within the literature there are two broad source areas for definitions of child abuse: the research and the official government legislative definitions. (see Corby 1993). As already discussed, Kempe et al (1962) limited their definition of abuse to the severely physically assaulted child (see Humphreys and Ramsey 1993). Clearly any subsequent changes to the definition utilised by Kempe and his colleagues would affect estimates of the size and extent

of the problem. As an example of this with regard to defining sexual abuse: Brierè and Runtz (1988b) researching post sexual abuse trauma define sexual abuse as any self reported sexual contact experienced by a client prior to the age of 15, initiated by someone 5 or more years their senior. The authors specify that the choice of this operational definition emphasises the relative youth of the victim, and the relative power of the abuser (Brierè and Runtz 1988b p 88). Doyle-Peters (1988) in her research on child sexual abuse and later psychological problems, defined sexual abuse as occurring before the subject was 18 years old, involving intentional and unambiguous sexual behaviour of a physical nature, involving a perpetrator who was at least 5 years senior to the victim, or using coercion to secure participation (ibid. p106). Despite the latter definition achieving what Corby (1993) refers to as the researchers aspiration to greater precision and consistency, the two works described would likely yield different results, despite examining similar phenomena, in the same year, in the same country. This point is not lost on researchers who recognise the difficulty in defining the phenomenon:

> 'criteria for child abuse/neglect are often questionable, vary widely and include unsubstantiated cases. Basic differences in the definitions or criteria for abuse or neglect affect not only the estimates of its frequency but also the replicability of assessment and research'
>
> *(Spatz-Widom 1989b p 4)*

There is also a recognition (as in the Brierè and Runtz 1988b research) that much of the child abuse research tends to be based on self report, and as with problems associated with definition, researchers have identified the failings of research utilising such methods (Spatz Widom 1989 b, Newcomb and Locke 2001). Despite recognising this method as problematic however Spatz Widom recently collaborated on research utilising a client self report methodology (see Weeks and Widom 1998). This is perhaps indicative of the difficulty in obtaining consistent and accurate records of child abuse, from sources other than the client themselves, rather than researchers not 'doing as they say'.

There is an element of fluidity and 'change', in the definitions of government legislation, as evidenced by Corby's (1993) continued reference to the 1991 Department of Health (UK) guidelines, which by the time of this research had been replaced by 1999 guidelines from the

Department of Health (DoH 1999c). It is noteworthy that in Britain formal definitions of child abuse have been formulated by the Department of Health, (Corby 1993 p 43), and it is clear that, compared to the research definitions, they tend to be subject to less variation, and are certainly more inclusive than exclusive, covering the range of maltreatment which is examined within this research.

The DoH (1999c) definitions of child abuse are as follows:

> '**Physical abuse** may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer feigns the symptoms of, or deliberately causes ill health to a child whom they are looking after.
>
> **Emotional abuse** is the persistent emotional ill treatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to the child that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may feature age or developmentally inappropriate expectations being imposed on children. It may involve causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of ill treatment of a child, although it may occur alone.
>
> **Sexual abuse** involves forcing or enticing a child or young person to take part in sexual activities, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative (e.g. rape and buggery) or non-penetrative acts. They may include non-contact activities such as involving children in looking at, or in the production of, pornographic material, or watching sexual activities or encouraging children to behave in sexually inappropriate ways.
>
> **Neglect** is the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. It may involve a parent or carer failing to provide adequate food, shelter and clothing, failing to protect a child from physical harm or danger, or the failure to ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.'
>
> *(DoH 1999c ps. 5-6)*

The section of the document from which the DoH definitions are taken is titled: 'Some lessons from research experience', which is perhaps indicative of a move toward evidence based practice guidelines. A section detailing the concept of 'significant harm' follows the definitions listed here. This is flagged as the:

> 'threshold that justifies compulsory intervention in family life in the best interests of the children'
>
> *(DoH 1999c p 7)*

Here the clinician is asked to consider severity of harm, duration, frequency, pre-meditation, degree of threat and coercion, sadism and bizarre or unusual elements in child sexual abuse. Single incidents of abuse are recognised as being as important as repeated acts, dependent upon the considerations as listed. The breadth of the definition of physical abuse can be honed somewhat in utilising both the guidance on the concept of significant harm, and the section on the impact of physical abuse (DoH 1999c p 6). With regard to emotional abuse Corby (1993) has illustrated how difficult it is to intervene on the basis of the definition used in the 1991 guidance. However the DoH (1999) document indicates how important it considers such abuse in terms of the potential impact it may have on the developing mental health of a child. This 'future element' of the 1999 definition of emotional abuse is useful for the researcher, if not for the practical application of such a definition. The definition of sexual abuse is comprehensive insofar as it describes both contact and non-contact behaviours as abusive. Similarly the child's awareness of the abusive act is usefully defined as not being of issue, which places the onus of responsibility for the abuse on the perpetrator. However age is only implied with 'child' or 'young person', specific reference to age of consent may have gone some way to removing that level of ambiguity perhaps. The definition of neglect in 1999 is expanded from the 1991 definition to include more specific areas of abuse, adequate 'shelter and clothing', 'failure to protect from physical harm or danger' and 'access to appropriate medical care or treatment' for instance are included in the 1999 DoH guidelines. The vague aspect of the definition of neglect however relates to 'adequate', and how we must take into account cultural, intellectual and material considerations in this area (see Corby 1993 p 46).

One of the key areas of address of this research project relates closely to how clinicians consider the severity of abuse suffered by a clinical sample. The literature as discussed, contains many contradictions related to definitions of violence and child abuse, which impact upon our ability to grade abused children in terms of severity of abuse experienced. I have already discussed the notion of co-existent forms of maltreatment, however the problems of definition can be seen to cloud the important issue of assessing severity of abuse:

> 'child abuse and neglect are on a continuum from the extreme to the mild, and every degree in between. Child maltreatment exists and is well documented, unfortunately professionals spend much of their time trying to decide what it is and is not'
>
> *(Humphreys and Ramsay 1993 p 38)*

The continuum of severity ranging from the mild to life threatening abuse has received some attention within the literature (Peckham 1980, Creighton 1988, Browne and Herbert 1997), but is still largely underplayed within the research generally. Spatz-Widom (1989b) recognized that the literature fails to provide direct evidence of the severity, frequency or chronicity of abuse. The reasons for such a lack of address may be, yet again, linked with associated methodological difficulties inherent in a severity approach, where child victims of violence are unlikely to be subject to only one form of maltreatment (see Browne and Herbert 1997 p 9). Similarly, as indicated in the earlier review of definitions (Corby 1993, DoH 1991, DoH 1999c) psychological and emotional abuse, as well as neglect are difficult to quantify for clinicians, particularly in understanding both forms, and severity of maltreatment, and the interrelationships between these two concepts, and as a way of classifying severity between less severe and life threatening. The authors (op.cit.) have devised a useful classification of severity incorporating descriptors of the range of abuse behaviours (see Browne and Herbert 1997 p 10) (Appendix Two). This robust series of descriptors of severity of maltreatment can be useful to the researcher and clinician alike in determining severity. They are a more comprehensive description of severity of abuse than more simplistic determinations of severity used within some research (see Downs and Millar 1998).

2.6 Prevalence

The themes of 'differential interpretations', and varied methodologies extend into studies of prevalence of child abuse. The size of any problem will be very closely associated with the definitions associated with the phenomena being examined and similarly estimates of prevalence will be closely linked to the population being studied (Glasser et al 2001 p 482). A range of estimates of prevalence of child abuse can be seen, dependent upon whether research data, or official government figures, are utilised. This variation is also seen in figures associated with the general population, and clinical populations. Browne (1993 p 150) cites Besharov (1982) who claims that this variation in estimation of prevalence is exemplified by American estimates. Here we can see the importance of how 'abuse' is defined where the range varies between 60,000 and 4,500,000 cases of child abuse each year (see Besharov 1982). Glasser et al (2001) cite Finklehor's (1981) estimates of college students, where 19% of female and 9% of male students were found to have been sexually abused as children. However this population of college students may not be representative of the population as a whole. Representativeness would clearly be influenced by methodological factors such as questionnaire surveys using broad questions, which tend to yield low rates, or higher rates achieved through focused direct interviews (Glasser et al 2001). Their work (ibid.), with a cohort drawn from a British forensic Psychotherapy clinic, found a prevalence rate of sexual abuse in childhood of 21%. The gender split within this cohort is unsurprising, given that it was a forensic clinical cohort (88% male and 11% female), the sample having a mean age of 31.2 years (Glasser et al 2001 p 484). As can be seen in research estimates of prevalence, the precise nature of definition, and available populations, may well give rise to a range of rates. For instance a research study into the prevalence and characteristics of child sexual abuse in female samples utilising an inclusive definition gave rates of prevalence as between 21-32% (Vogeltan et al 1999). Within the work (ibid.), which had 1099 subjects within its sample, a less inclusive definition of sexual abuse gave rates of 15-26%.

Catherine Spatz-Widom has seemingly grappled with the flawed methodology inherent in such work over the years, yet has continued to conduct prevalence studies despite her own, and others, criticism of the lack of standard definitions, the lack of a standard upper age limit,

the lack (in child sexual abuse) of agreement about age difference between victim and perpetrator, the range of sample selection and data collection methods (Widom 1989b, Corby 1993, Weeks and Widom 1998, Glasser et al 2001). Her 1989 critical review of the literature on prevalence findings in clinical settings summarises many of the problems associated with such work (Spatz Widom 1989b). She relates how many of the studies are based on small numbers of violent or homicidal offenders. In examining a range of reports from the early 1960's through to the mid 1980's she variously comments on research samples of 8 boys, 6 prisoners, 9 adolescent boys, 30 adolescent boys, 10 mothers and so on. She (ibid.) bemoans the lack of case histories of psychotic patients, as well as poor control groups and a dependence upon retrospective reports. (see Spatz Widom 1989b p 8). She recognises the importance of clinical works, such as those discussed, particularly in stimulating further research, but expresses concern over the statistical usefulness of such work (Widom 1989b p 9). The work of Widom, particularly with reference to this research, with those resident in institutions is illuminating, both in terms of prevalence, and the inherent problems in estimating prevalence rates. Despite the commonly held belief that many resident within institutions have been victims of physical abuse/neglect there is a paucity of research in this area (Weeks and Widom 1998). In advance of briefing the reader of their research they (ibid.) critique the lack of uniformity in criteria for childhood abuse and neglect, as well as variation in measurement techniques, making comparison of data difficult (Weeks and Widom 1998 p 348).

Interestingly, with regard to the danger associated with retrospective self reports the authors comment:

> 'it is possible that residents forget or redefine their own behaviours in accordance with later life circumstances and their current situation'
>
> *(Weeks and Widom 1998 p 384)*

This is a key shortfall in some respects with prevalence estimates, only knowing what we are told. This is a recurring theme within the literature, the idea that reported, rather than actual cases of abuse are the cases that make up the prevalence rate (see Creighton 1988). Weeks

and Widom (1998) further warn the reader that evidence of childhood victimization within their sample of incarcerated prisoners does not necessarily indicate etiology or causality, rather such evidence assists policy makers in selecting appropriate treatment services. They (ibid.) found that the use of different measures of scale revealed different rates of abuse in their sample of 301 convicted prisoners, who were all aged 17 or over. 34.9% of the sample reported physical abuse in childhood, but in using another scale of measurement 58.1% reported physical abuse. 30% of the sample reported sexual experiences prior to the age of 12, and 16% reported some form of childhood neglect. Having reported difficulty in comparing findings in this field the authors created a composite variable representing all abuse, and found that 68.4% of the sample reported some form of early childhood victimization. Interestingly no difference in the extent of abuse was reported between violent and non-violent offenders (see Weeks and Widom 1998, p 353-354). The precise nature of operational definitions within research studies of prevalence are useful in terms of the associated findings, which as suggested by Weeks and Widom (1998) do not infer causality, but can guide our assessment and interventions.

Wilshaw (1999) relates that sexual abusers tend to be known to their victims, usually in established relationships of trust and power, citing Renvoize (1993) and Rush (1980) in support of this observation. North American findings have revealed that 54% of abusers were blood relatives, within the family (Rush 1980). Utilising research such as this can clearly focus the family assessment a clinician could undertake. Browne (1993) indicates that newspaper reports during 1991 identified 99 children under 16 years of age who died of non-accidental injury (England, Scotland and Wales). However he (ibid.) goes on to reflect how likely this is to be an underestimate of the true figure in light of the National Society for the Prevention of Cruelty to Children (NSPCC) figures of 3 children dying each week at the hands of their parents (Browne 1993 p 149). Such disparity associated with research, official and clinical estimates of prevalence are further highlighted by Browne (1989) who illustrated how the sum total of case conferences involving physical, psychological and sexual forms of abuse and neglect involved about 1% of English children. Browne and Herbert (1997 p 12) reflecting later on this work reported how only half this figure will be on a child protection register at any one time (making reference to the DoH Child Protection Register of 1995).

Since 1990 the Department of Health has assessed, each year, the number of children and young people on child protection registers in England. The child abuse registers, maintained by the NSPCC, are extremely useful, not in identifying causality necessarily but pointing researchers and clinicians alike in the direction of fruitful avenues of clinical exploration and assessment. The maintenance of the registers has been called:

> 'the largest continuous survey of child abuse being carried out in the UK'
>
> *(Creighton 1988, p 31)*

Whilst recognising the usefulness of the registers Creighton (ibid.) brings attention to the fact that they are a record of reported, rather than actual, occurrences of abuse. Nevertheless the record is *the* national statistic, used by the Department of Health, and posted annually. The main findings for the year ending 31st march 2001 were that 26,800 children were on child protection registers, a figure representing 24 children per 10,000 of the population. This figure represented a decrease of 8% for registrations than in the previous year. Of note was the rise in the registration of children at risk of neglect (46% of registrations during 2000/2001) a steady increase since 1997. The DoH (2001 URL) further reports a fall for registrations under the category physical injury and sexual abuse.

The NSPCC (2001 URL) summarise child protection register statistics by category of abuse as follows:

Table 3: NSPCC Child Protection Register Figures (2001)

Category of Abuse	Year 2001 (England)
Neglect alone	10400
Physical injury alone	5000
Sexual abuse alone	3200
Emotional abuse alone	4800
Neglect, physical and sexual abuse	200
Neglect and physical injury	1600
Neglect and sexual abuse	700
Physical injury and sexual abuse	400
Categories not recommended by 'Working Together'	400
No category available – transfer pending conferencing	100
Total of all abuse categories	**26800**

(NSPCC URL 2001)

Interestingly both the DoH (2001 URL) and the NSPCC (2001 URL) include within their information accompanying child protection data, indicating that the registers are not a record of all child abuse, but that the aim of such record systems is to assist in the protection of children. Despite the usefulness of such registers criticism has been leveled against the ways in which data is recorded, related to the ways in which local authorities practice in different ways (see Corby 1993). The ways in which registers are maintained have changed over the years also. In the late 1970's and early 1980's children's names remained on the register for longer periods than today. Corby (op.cit.) reports how in 1990-91 there were 26,600 de-registrations. The DoH (2001 URL) report that for the year ending March 2001 30,200 children were de-registered. Corby (ibid.) also alludes to the heightened sensitivity to child maltreatment issues, and how profile cases in the media may give rise to an increase in reported cases. Similarly more sophisticated and elaborate systems of response (Corby 1993 p

53) may account for figures, which reflect the increase in identified cases of neglect between 1997 and 2001 (NSPCC 2001 URL).

The conclusions from prevalence studies, despite their shortfalls, appear to indicate that the phenomenon of child maltreatment is a serious and progressive social problem. Corby (1993) citing Lafontaine (1990) reflects upon sexual abuse of children, and how even the lowest estimate of its prevalence is indicative of a large number of children being involved. Reported cases, regardless of under reporting, reflect a figure of almost 30,000 cases of child maltreatment in England alone (DoH 2001 URL), and this clearly warrants further research and health and social services intervention.

2.7 Cycles of Violence

This section of the review will examine the pathways associated with victimisation in childhood, and elements of developmental psychopathology. An attempt to explore the literature and research associated with examining the link between types of abuse in childhood, and the links to violence, offending and mental disorder, will be undertaken, so as to further explore combinations of variables and risk factors mediating early abuse and later behaviour.

Many authors have recognised the neglect of the inner world of the offender, and the need for a greater focus on the effects of abuse, which can in turn reduce the chances of abuse or violence being repeated from one generation to another. (Blumenthal and Lavender 2001 p 78, Corby 1993 p 106).

We seem to have reached a position at the end of the twentieth, and the beginning of the twenty first century, where sustained research effort in this area over the last 40 years is now officially recognised:

> 'The sustained abuse or neglect of children, physically emotionally or sexually can have major long term effects on all aspects of a child's health development and well being. Sustained abuse is likely to have a deep impact on the childs self image and self esteem, and on his/her future life'
>
> *(DoH 1999c p 6)*

This quote from a Department of Health document, which has been reported to this author to be 'the bible', to those working in child protection circles, assists those working in the field to promote the welfare of children. The belief of such professionals, and of the public at large, in a cycle of violence, where abused children become abusers, and victims of violence become violent victimisers, is pervasive (Spatz-Widom 1989b p 3). Blumenthal and Lavender (2001) describe the ways in which the internal world of the offender has been largely ignored, this world containing rich information relating to:

> 'the individuals background, disrupted familial bonds, violence experienced during childhood, as well as the meaning of the violence to the perpetrator'
>
> *(Blumenthal and Lavender 2001 p 79)*

The authors (ibid.) comment on the value of assessing such information, particularly in forensic settings, to enable a more detailed understanding of offending behaviour (Blumenthal and Lavender p 81). Spatz-Widom (op.cit.) reminds the reader of the need for specificity in this area when she comments on how such phrases as 'cycles of violence', and intergenerational transmission of violence', have been used loosely regarding the consequences of abuse. Some authors write exclusively on the notion of abused children becoming abusive parents, whereas others focus on violent or criminal behaviour as consequences of childhood abuse (see Spatz-Widom 1989b p 4). It has been suggested (ibid.) that the emotional and developmental change experienced by children who are abused may persist into adulthood.

The mediating factors, which contribute to maintaining behaviours such as aggression and violence, are examined within the literature and research also. We have already reviewed how some authors, (Blumenthal and Lavender 2001 p 81) view examination of repeating patterns of behaviour as a way of bringing to life early relationships a patient may have experienced. They (ibid. p 5) emphasize the role of developmental psychopathology in this process, and of how such study can assist in examining the links between certain factors in childhood, and outcomes of violence or mental disorder. Many authors report the importance of learning theory, modeling, developmental psychology, and of how in relation to violence and aggression, they can function as a guide for future action (Bandura 1973,Owens and Straus 1975, Herzberger 1983, Hanrahan, Campbell and Ulrich 1993, Browne and Herbert 1997). Conclusions in this area of study tend to reflect the work of Owens and Straus (1975), who relate that the frequency with which a child witnesses or experiences violence in the home or social structure, the higher likelihood that the child will perform such violence, having seen the behaviour modeled. Browne and Herbert (1997) cite Bandura (1973) who notes how individuals observe the effects of their actions, forming hypotheses about which behaviours are most appropriate in varied situations (see Browne and Herbert 1997 p 47). They (ibid. p 48) suggest that complex or novel behaviour, adaptive or maladaptive, is acquired by observing the behaviour of exemplary models. This 'observational learning' the authors suggest, is considered by social learning theorists to be the cornerstone of learning for socialisation (ibid. p 48). This concept is realised by Spatz-Widom (1989b) when she relates how:

> 'Physical aggression between family members provides a likely model for the learning of aggressive behaviour and for the appropriateness of such behaviour within the family'
>
> *(Spatz-Widom 1989b p 4)*

Coercive family dynamics, and relationships within the family have been the focus of work examining developmental aspects of aggression (see Browne et al 1988, Browne and Herbert 1997). The concern, in terms of long-term sequences of behaviour, can be seen when parents fail to cognitively structure, or sanction, non-compliant or coercive behaviours in their own

children. Browne and Herbert (1997) outline how in some families there may be extreme inconsistency in such areas, to the extent where there are positive consequences for anti social behaviour, and even punishment for pro social actions. This could well lead to the:

> 'Persistence of anti social and coercive actions as part of a child's behaviour repertoire'
>
> *(Browne and Herbert 1997 p 51)*

The authors (ibid.) infer that there is a clear link between the concept of the intergenerational transmission of violence and social learning theory:

> 'A child learns to be violent in the family setting in which a violent parent has been taken as a role model'
>
> *(Browne and Herbert 1997 p 233)*

Such learned behaviour will, when frustration or anger occurs in adulthood, manifest as abusive behaviour in turn (Browne and Herbert 1997 p 233). Herzberger (1983) reflects this theme of social learning theory as being instrumental in promoting what she terms 'retaliatory norms.' Such norms she maintains:

> 'Mark the beginning of aggressive motivation and provide the moral basis for violence against others'
>
> *(Herzberger 1983 p 319)*

She (ibid. p326) maintains that there are three mechanisms by which abuse is transmitted:

- Teaching children that aggressive behaviour is appropriate
- Failing to teach children an internalised morality
- By transferring a particular self or interpersonal perspective from parent to child

These mechanisms can therefore be seen as some of the ways in which 'retaliatory norms' are established and maintained.

The support for a 'cycle of violence' hypothesis has according to Blumenthal and Lavender (2001 p 83), been firmly established empirically over the last 10 years. The authors (ibid) cite Ryan (1989), who suggests that as many as 70% to 80% of adult sexual offenders have suffered sexual abuse as children, as well as Lewis et al (1980) and Fitch and Papantonio (1983) who report how violent boys have been found to be more likely to have experienced or witnessed extreme physical abuse. There are indeed a number of studies supporting a 'cycle of violence' hypothesis (Dutton and Hart, 1992, Walsh and Rosen 1988, Spatz-Widom 1989a, Weeks and Widom, 1998, Kratcoski, 1982, Weiler and Widom 1996). Dutton and Hart's (1992) study involved 604 prison inmates. Those abused, as children were 3 times more likely to have engaged in violence as adults than those inmates who had not been abused. Violence to self in the form of self-mutilation has been addressed by Walsh and Rosen (1988). The authors (ibid.) suggest that sexual abuse experienced in childhood leads to a form of body alienation, the authors further suggesting that children witnessing self-mutilation, alcohol abuse and/or drug abuse in parents are correlated to self-abuse in later life. Spatz-Widom (1989a) relates a 2 year research project she engaged in examining the relationship between child abuse and neglect and later violent criminal behaviour. Having incorporated methodological improvements (the subject of much criticism in this area, to be discussed later in this review section) the author examined 908 cases, data were drawn from the case files of juvenile courts and probation departments, and adult criminal histories from official sources. A matched control group was used. This exacting research, utilising unambiguous operational definitions and a prospective design, with a matched control group, and an equal gender split, found that abused and neglected children had a higher likelihood of arrests for delinquency, adult criminality and violent criminal behaviour than the control group. She (ibid.) further found that victims of physical abuse had the highest levels of arrest for violent criminal behaviours, followed by victims of neglect. Clearly there are limitations in this research, which is still precise and exacting by other standards. There is an exclusive reliance on official records for example, the findings reveal violent criminal behaviour, not violent

behaviour in the sample, as a consequence of using official arrest records. Despite such limitations Spatz-Widom concludes that:

> 'Early childhood victimisation has demonstrable long-term consequences for delinquency, adult criminality and violent criminal behaviour. The results provide strong support for the cycle of violence hypothesis'
>
> *(Spatz-Widom 1989a p 164)*

Despite her findings in this 1989 work Widom, in collaboration with Robin Weeks found, almost 10 years later, that neglect was the only form of childhood victimisation differentiating violent and non-violent groups, which in turn increased the risk of violence. This research (Weeks and Widom 1998) examined self-report measures of childhood victimization on 301 convicted prisoners. There was no significant difference in the retrospective reports of childhood physical or sexual abuse between violent and non-violent offenders. The age limit of 12 years (for abuse having occurred) whilst restrictive, still provided a high rate of abuse being disclosed in the sample, 68.4% of subjects having revealed some form of victimisation within the definition of abuse used within the research.

As indicated earlier there is a growing literature in the area of family dynamics, particularly in relation to abuse. 'Cycle of violence' theorists do not ignore this area, Kratcoski (1982) examining the relationship between child abuse, and adolescent's later violent behaviour toward family members. The author (ibid.) stresses that social learning theories and stress models are best applied to the examination of violence directed at family members. This is in contrast to a model of violence examined within a 'culture of violence' model reflecting the pressure of survival in any given society. Kratcoski (1982) utilised case file analysis on the sex age race and number of offences, as well as abuse histories, of a sample of 883 delinquent adolescents. 26% of the sample had experienced physical abuse, and 75% of both abused and non-abused youths had committed at least one violent act. In those who had engaged in violence toward persons 45% of abused youths directed the violence to family members or caregivers. In comparison, 18% of the non-abused youths directed violence towards family or caregivers. This work (ibid.) is indicative of an attempt to examine context, and mediators of

violence in an area of research where violence is usually examined as occurring in group situations. Kratcoski (1982) maintains adolescent violence, against family members is usually the result of low frustration tolerance, poor coping skills, immaturity and poor verbal reasoning (and verbal skills generally) in the violent adolescent (ibid. p 443). The effects of mediation in abused children and later violent behaviour are areas examined by Weiler and Widom (1996) who examined the interrelationships among early childhood victimization, psychopathy and violence, in a sample of previously abused and neglected individuals. The sample (n=652) had a matched control group (n=489). The authors (ibid.) used a measure of psychopathy, the psychopathy checklist revised, (PCL-R) (Hare 1991), and determined violence through official arrest records and self-report information. The work went as far as breaking down definitions of types of abuse, restricting the age limit to 11 years or under (when the abuse occurred). This examination of mediating factors led to multivariate analysis, which found that victims of childhood abuse/neglect had significantly higher PCL-R scores than those in the matched control group, and that such victimisation was a significant predictor of violence. The suggestion within the work is that the relationship between victimisation and violence, in some individuals, is mediated by psychopathy:

> 'the present findings suggest that the relationship between childhood and victimisation and violence may be mediated by psychopathic symptoms. That is, childhood abuse/neglect may increase a persons risk for psychopathy which in turn may put one at increased risk for violent behaviour'
>
> *(Weiler and Widom 1996 p 264)*

The authors (ibid.) are careful however in not inferring causality between any of the three variables, highlighting the fact that there is a possibility of none of the three variables, victimisation, psychopathy or violence, being causal in nature, but perhaps another variable, such as genetics being the key.

As with the research supporting a link between being victimised and later violent behaviour, there is also research supporting specific types of abuse and later violence, and psychopathology. Child sexual abuse is such a type of abuse covered extensively within the literature (Groth and Burgess 1979, Briere and Runtz 1988, Finklehor 1988, Wyatt and Powell

1988, Cole and Putnam 1992, Fiering et al 1999, Glasser et al 2001). The mediating factors between early victimisation and later negative consequences have been suggested as abusive incidents, which concern:

- Fathers
- Genital Contact
- The use of force

(Wyatt and Powell 1988 p 14)

Such factors would clearly have impact upon a child, promoting significant distress in those who may re-experience such trauma later in life. Finklehor (1988) writes of the model most frequently associated with such distress, a post-traumatic stress disorder model (PTSD). He (ibid.) discusses the diagnostic considerations of having experienced such distress, a numbing of responsiveness, and reduced involvement in the external world, sleep problems, survival guilt and problems, with memory and concentration (American Psychiatric Association 1980). Finklehor (op.cit.) proposes a model of traumagenic dynamics to account for a child's changed cognitive or emotional orientation to the world. This model effectively incorporates the range of effects of child sexual abuse, traumatic sexualisation, betrayal, stigmatisation and powerlessness (see Finklehor 1988 p 68). The research appears to support childhood sexual abuse being associated with a range of dysfunction in adulthood notably dysphoric mood, negative cognitions, interpersonal problems, self-destructiveness and revictimisation (see Briere and Runtz 1988b p 85). Groth and Burgess (1979) found that one third of child molesters in their study had reported some aspect of sexual trauma in their own childhood. Fiering et al (1999) addressed developmental mediators between abuse and later psychological distress by focusing upon age at time of discovery of abuse, and gender of the victim. The authors (ibid.) found that adolescents, compared to children, reported higher levels of depressive symptoms, and that poor adjustment has been associated with severe levels of sexual activity. Both Walsh and Rosen (1988) and Cole and Putnam (1992) identify that adult self-mutilation is a frequent symptom encountered in those who have been sexually victimised in childhood/adolescence. More recently Glasser et al (2001) have examined cycles of child

sexual abuse in a sample attending a British Specialist Forensic Psychotherapy Service. Interestingly, as compared to the bulk of the research in the area of child sexual abuse, this research was not reliant upon the subject accounts and memories of childhood, and this, coupled with clinicians all working to the same definitional criteria and consistency of decisions, make the research somewhat unique. The findings of the study are supportive of a cycle of sexual abuse in a clinical population. 21% of the sample (n=843) were victims of abuse, 135 men and 41 women. 27% of the sample were found to be child abusers, 73% were not. The abuser group comprised all men with the exception of 2 women (252 vs. 2). The mean age of the sample was 31.2 years. Of the 41 females attending the service who were victims of sexual abuse, only one proved to be a perpetrator, however of the 135 male victims 79 were perpetrators (see Glasser et al p 485). This work indicates that the key factor of discontinuity in the cycle would appear to relate to being female.

I have briefly touched on the literature and research supporting links between early victimisation and the development, in adulthood, of mental illness or general psychological distress. As with the research linking victimisation and later violent behaviour, the former is a developing area of research (see Carmen et al 1984, Finklehor 1988: Briere and Runtz 1988b, Doyle Peters 1988, Hermann Perry and Van der Kolk 1989, Cole and Putnam 1992, Weiler and Widom 1996, Browne and Herbert 1997, Hiday et al 1999, Fondacarro et al 1999, Macmillan and Mann 2001, De Bellis et al 2001). Other than a general theme of links between victimisation and later psychological disturbance, it is difficult to pin down one specific theme. This is well illustrated in the themes addressed within this cited literature. These themes relate to areas as wide as the range of disorders suffered in adulthood (Fondacarro et al 1999), to an examination of mental disorder among perpetrators (De Bellis et al 2001), to specific disorders such as depression (Doyle Peters 1988). However there does appear to be general support for a range of psychological distress experienced in the childhood of victimised individuals. An illustration of this is found in the work of Weiler and Widom (1996), indicating the raised psychopathy scores of those individuals abused in childhood/adolescence. Cole and Putnam (1992) in examining incest, and its effects on the self, further discuss borderline and multiple personality disorder as symptoms resulting from childhood sexual abuse. The authors (ibid) illustrate how self-mutilation is one of the range of

behaviours which is linked with earlier abuse also, a theme similarly identified in Walsh and Rosen's (1988) work. This review has already discussed the work of Finklehor (1988) with regard to his view of traumagenic dynamics associated with childhood sexual abuse. Briere and Runtz (1988b) examined the history of such trauma in a sample of 152 women requesting appointments at a crisis counselling department in a Canadian Health Centre. 44% of this sample had a history of child sexual abuse. No significant differences were revealed in the abused and non-abused subjects in terms of age, marital status or ethnicity. Briere and Runtz (ibid.) however, found that subjects who had been abused were significantly more likely than non-abused clients to be currently taking psychoactive medication, and have a history of substance addiction. Further to this the abused subject group were more likely to have been victimised in an adult relationship, made at least one suicide attempt in the past, and were more likely to have reported a variety of dissociative experiences, sleep problems, anxiety, and problems with anger and self destructiveness (Briere and Runtz 1988b p 86-89). Substance abuse and depression as a key outcome variable of earlier child sexual abuse was addressed by Doyle Peters (1988). The author hypothesised that women who experience contact abuse prior to the age of 18 years will exhibit greater psychological difficulty as adults than women who experienced no, or non contact abuse. The author further hypothesised that the severity of contact abuse would be related to the degree of psychological disturbance. 60% of the sample (n=119) reported at least one incident of sexual abuse prior to age 18. A total of 128 incidents were reported from a range of perpetrators, 51% of the abused women having been abused by 2 or more perpetrators. Strangers made up the majority of perpetrators in non-contact incidents, but contact abuse experiences tended to involve someone known to the victim (45% acquaintance, 35 % family member). All perpetrators were male. The research also found that the contact abuse groups were significantly more likely to have experienced alcohol abuse, drug abuse, and at least one major depressive episode. In examining severity Doyle Peters (ibid.) found that duration of abuse experienced, and being older when the last incident occurred (abuse was defined as having occurred prior to age 18 involving a perpetrator of at least 5 years seniority) were related to a greater psychological difficulty in adulthood, as were a number of contact abuse incidents (Doyle Peters 1988 p110). Interestingly in this work (ibid) abuse histories limited to non-contact experiences were not associated with depression or substance abuse in adulthood. Browne and Herbert (1997 p246) illustrate how the research

in this area has examined victims of abuse who in turn express their distress through abuse of drugs and alcohol. They (ibid.) write of the majority of the literature in this area, child abuse and subsequent trauma, as being American. The inference here would appear to relate to the generalisability of findings from one culture to another. They further illustrate, in predicting trauma associated with earlier child abuse, how some later effects may be as a result of more than one dynamic, depression for instance being a sense of betrayal or powerlessness, (Browne and Herbert 1997 p 248). It is clear that such ambiguity in establishing links between the two phenomena makes the understanding of how abuse characteristics influence psychopathology more difficult.

Despite such ambiguity in establishing the link, the rates of different types of experienced abuse, among those with a mental disorder has been reported as high as 81% (Hiday et al 1999). Carmen et al (1984) examined a sample (n=188) of patients in an American Psychiatric Hospital. The authors (ibid.) focused on case file analysis of the sample, reviewing abuse in childhood, or as wives. 43% of the sample had histories of abuse. 80% had been physically abused, 50% sexually abused, 90% had been victimised by family members. Examination of individuals with mental disorder has also revealed a greater frequency of abuse victimisation within families (Hermann, Perry and Van der Kolk 1989), and a greater degree of mental disorder in caregivers who are involved in maltreating their charges (see De Bellis et al 2001). The association between childhood sexual victimisation and adult psychiatric disorders has been researched within an institutional setting also. Fondacarro et al (1999) examined a sample of male prison in-mates (n=211). They found significant differences in those with a history of child sexual abuse and those with no such history in terms of psychiatric diagnosis. The abused group had significantly raised frequency of diagnosis such as generalised anxiety disorder, depression, obsessive compulsive disorder, post traumatic stress disorder, panic disorder and schizoaffective disorder.

Briere and Runtz (1988b p93) suggest that even a conservative estimate of 20% of sexual abuse victims suffering major long term effects, is indicative of a large number of individuals experiencing significant psychological symptomatolgy in adulthood. The impact that such figures have on mental health practice is a clear indication of the need for greater focus on this

area, and an indication to clinicians of the need to address what may be unresolved traumatic childhood experiences.

2.8 Methodological Considerations

A greater degree of specificity would appear to be required in reviewing and researching the links between abuse suffered in childhood and adolescence, and later abusing or violent behaviour, and its links to mental disorder. Interestingly the literature is generally supportive of a figure of around 30%, or one third, in terms of intergenerational transmission of abuse rates (Spatz-Widom 1989a, Kaufman and Zigler 1987, Oliver 1993, Browne and Herbert 1997). Oliver (1993), in reviewing the literature, inferred that this figure of one third could be expected to become larger as time progressed, in suggesting that one third of victims grow up to repeat patterns, and one third do not, and the remaining third would be vulnerable to the stress which may lead to abusive parenting. Kaufman and Zigler (1987) reported a 30% transmission rate of abused children, becoming abusive parents, as have Browne and Herbert (1997) who reported a rate of repeating patterns of violent interactions among disturbed young people as between 20-30%. The rate of intergenerational transmission of abuse has also been estimated following a review of the literature, as between one fifth and one third (Spatz-Widom 1989a). My earlier reference to specificity in this area relates to the difference between the references to intergenerational transmission of abuse, abused child to abusing parent, (Kaufman and Zigler 1987, Oliver 1993), and repeated patterns of violent behaviour (Browne and Herbert 1997). Operational definitions and the specifics of methodology often make such studies very different in terms of focus and results. However, the figures do tend to reflect findings of about one third in both areas of study, not consistently, but frequently enough to be of interest to those working in clinical mental health settings. Some of the research reflecting findings of rates of abuse suffered in a range of samples has been discussed already, earlier in this review section. Browne and Herbert's (1997) suggestion that the figure of 20-30% of disturbed young people continuing violent interaction into adulthood is reflected in figures relating to abuse being discovered in other samples also, Kratcoski (1982) finding 26% of his sample having endured abuse in childhood. Spatz-Widom (1989a) also reported 26% of her sample of abuse victims having juvenile offences. The work of Spatz-Widom

(ibid) is different in context to that of Kratcoski (op.cit.), but, I would suggest, has increasingly become part of the confusion, which led Kaufman and Zigler to reflect on their own earlier work, and the work of others, in relation to the 30% transmission rate estimates:

> 'Uncritical acceptance of the intergenerational hypothesis has caused undue anxiety in many victims of abuse, has led to biased responses by mental health workers, and has influenced the outcome of court decisions...
> Although a transmission rate of 30% is hardly consequential, it is a far cry from the 99% figure promulgated in the popular press'
>
> *(Kaufman and Zigler 1993 p 218)*

The manner in which phrases such as 'intergenerational transmission of abuse,' and 'cycles of violence' have been used loosely (Spatz-Widom 1989b) has been illustrated earlier in this work, particularly in conjunction with the wide range of definitional interpretations of what exactly constitutes an abusive act. However the nature of definitions of abuse is only one of the methodological problems associated with work in this area.

The same methodological flaws inherent within studies associated with an abuse breeds abuse hypothesis can also be found in hypothesis based around abuse breeds violence (Spatz-Widom 1989b). This work (ibid.) clearly recognises the appeal of a notion of a cycle of violence, particularly in clinical populations, this may account for the over zealous adoption of the theory amongst the general public outlined by Kaufman and Zigler (1993) (see earlier). However, she (op. cit.) advises caution in inferring a simple causal link between victimization and later violent behaviour, illustrating how other events in a child's life, such as social supports, natural ability, and physiological predisposition may make the consequences of early victimization difficult to determine. Similarly Browne and Herbert (1997) point to caution in this area suggesting that the effects of early abuse may be as a result of more than one dynamic. The authors (ibid.) cite depression as an example, suggesting that such a disorder may occur as a function of the earlier powerless state the child may have experienced, or depression being a function of the sense of betrayal an adult has, having been victimized as a child. Establishing a particular variable as a cause thus becomes more difficult.

Unsurprisingly, largely due to the extensive amount of work conducted by herself, and in collaboration with research colleagues, Spatz-Widom has been very critical of the methodological limitations in this area of research. Her seminal works in this area (Spatz-Widom 1989a, Spatz-Widom 1989b) review the literature and evidence base for the phenomena, and relate some of her own research also. She illustrates how, within the literature examining whether violence breeds violence, there is little evidence of severity, frequency or chronicity of abuse (Spatz-Widom 1989b). She (ibid.) also illustrates how the use of self-report among subjects can give rise to retrospective recall bias and a tendency to slippage in accuracy. She further suggests that individuals may redefine their experiences in light of current behaviour, that the research suffers weak sampling techniques, and a failure to distinguish between types of abuse, and abuse and neglect. She (ibid.) relates many of the problems (previously identified in this review) associated with definitions of abuse, exclusions from the research, age differences and limits, and self report. In respect to the latter she cites research, which is reliant on the parents reports of a history of abuse, without any substantiation or validation (Spatz-Widom 1989b p 7). These themes are identified throughout the literature. Blumenthal and Lavender (2001) are critical of the research examining childhood experiences of the mentally ill, particularly in its reliance on self-report, small-scale clinical samples and poor use of baseline data. Many have criticised the overuse of case studies and summarised case reports in the research examining cycles of violence (Herzberger 1983, Briere and Runtz 1988, Newcombe and Locke 2001). Case studies tend to relate patterns of behaviour and experience, both distal and proximal, and the cycle of violence literature does cite case review and case study extensively. However, the literature and research in this area has been criticised as not examining maltreatment as a continuum, and failing to differentiate between types of maltreatment (Newcombe and Locke 2001).

Spatz Widom herself attempted to overcome many of the methodological problems briefly discussed here (see Spatz-Widom 1989a). She ensured, in a 2 year research project examining abused and non abused children's later adult criminal and violent behaviour, clear operational definitions of abuse and neglect, a prospective design, differentiating between types of abuse, and the generation of a matched control group. However, she was critical of her own work (ibid.) in its exclusive reliance on official records, warning that we should not generalize

inappropriately her findings that victims of physical abuse had the highest level of arrests for violent criminal behaviour. In later collaborative work (Weiler and Widom 1996) examining the interrelationships between childhood victimization, psychopathy and violence the author(s) again identify design flaws related to their limit on abuse having occurred in their subjects prior to age 11, as well as the potential for under reporting of abuse in their control group. This latter phenomenon, of unreliability in the reporting of child abuse is discussed in work by Fergusson, Harwood and Woodward (2000). Here the authors (ibid.) comment on unreliability as a direct consequence of subjects of abuse providing false negative reports. Glasser et al (2001) in examining cycles of child sexual abuse in a forensic psychotherapy service population identified limitations in their own work. They (ibid.) recognised that their population was already a high-risk group for both experiences of childhood sexual victimization, and for being a perpetrator.

However, despite such limitations they (ibid) suggest an approach, which may contribute to overcoming many of the methodological problems encountered in such research:

> 'it is argued that the case notes were prepared by clinicians all working in the same theoretical framework, with the same concepts and using the same definitional criteria with codings made under strict conditions so as to ensure consistency of decisions about the presence and absence of the specified features'
>
> *(Glasser et al 2001 p 493)*

However, even whilst overcoming much of the difficulty associated with such research, an advantage can easily be seen as a disadvantage. The authors (ibid.) relate how data gathering was not reliant on subject accounts or memories of early life, and of how case records alone were utilised in this respect. Despite this apparent advantage however the authors recognise that their decision to assume that non-reporting of psychopathology constitutes non-existence was an assumption, which many may view as questionable.

Despite the methodological flaws and limitations however the transmission rates are not inconsequential (Kaufman and Zigler 1993). We should not underestimate the research, which indicates that:

> 'Many physically abused children suffer considerable emotional and psychological problems.
>
> *(Corby 1993 p 116)*

The research continues to provide the evidence that a child who is sexually, physically or psychologically abused over a period of time, in a family environment, which is maladaptive and/or dysfunctional, is likely to become an aggressive youngster and/or have psychological problems. The example clearly set by the likes of Spatz Widom and others, is that problems with methodology should not be a barrier to extending the research in this field.

2.9 Violence, Crime and Mental Disorder. Factors in Childhood and Association with Outcomes

The course of victimisation, as reviewed within this section of the research project, can be a complex and lengthy process. The examination of the victimisation process, which occurs as a consequence of child abuse, can serve us well in analysis of the links between such abuse and the prevalence, and phenomena, of mental disorder and/or violent offending in later life (see Hamilton 1987). This review has already briefly touched on the literature addressing the associations and linkage between childhood maltreatment, offending and violence. Whilst there are complexities to be taken into account regarding this latter relationship, it is worth reflecting briefly upon some of the debate, which surrounds the relationship between criminal behaviour and mental disorder, to illustrate the complex nature of the relationships, and the dangers of ascribing causality between such variables.

Mustill (1991) has discussed the term 'mentally disordered offender' as an artificial construct, and advises caution in assuming that because the two populations (offenders/mentally disordered people) overlap, that there is a direct relationship between the two. Mustill (ibid.) relates how neither of the two overlapping populations is homogenous, characteristics of the members varying in both kind and degree.

Prins (1995) in closely examining common misunderstanding concerning offenders, deviants, and patients and the risk they may, or may not present, relates the confusion and ambiguity among both the public and some professionals:

> 'it is important to recognise that not all mentally disordered offenders are dangerous, and that not all dangerous offenders are mentally disordered'
>
> *(Prins 1995 p 229)*

There is however a common belief that extreme crime, which involves gross mutilation, or severe sexual assaults for instance, involves perpetrators who must be sick or mentally disordered. Fortunately such offences are statistically unusual, and whilst not culturally acceptable Howells (1982) reminds us that such crimes are not the result of physical or organic dysfunction, nor a product of mental illness. Thus we are led into the conundrum that:

> 'as a consequence judgments of mental abnormality tend to depend on subjective moral criteria rather than on medical criteria'
>
> *(Howells 1982 p 164)*

Howells (ibid.) argues that such conceptual difficulties can produce spurious correlation between disorder and crime. The general perception of causality, Howells argues, occurs because mentally disordered people do sometimes behave in a violent manner, and offenders can sometimes be shown to be schizophrenic, leading observers to conclude that psychiatric disorder is causal of deviant behaviour. However correlation is not evidence of causality.

The growth in the interest of the relationship between mental disorder and crime may actually reflect the developed and 'changed' interactions between the criminal justice and mental health systems, as opposed to any increase in scientific concern (see Blackburn 1995).

Cultural shifts in the management and treatment of the mentally ill may account for such a changed relationship:

> 'concerns about the 'psychiatrisation' of crime, however, have been paralleled by concerns over the 'criminalisation' of mental disorder, reflected in claims that the deinstitutionalisation of mentally ill people has led to more of them being processed by the criminal justice system'
>
> *(Blackburn 1995 p 246)*

Blackburn (ibid.) relates the popular notion, as did Howells (1982), that criminals are sick, this disease analogy finding its way into the criminal justice system. This model, Blackburn suggests, has become so pervasive as to include Psychologists, who usually distance themselves from a medical model of criminality. He suggests that Psychologists follow a medical analogy, looking for 'cure' through therapy, psychological interventions in anti-social behaviour becoming an application of treatment, which is expected to 'cure' the patient (see Blackburn 1995 p 250). Interestingly, this argument, revolving around a critique of the positivist tradition related to identification, prediction and control of crime, as if it were a disease process, was picked up by many nursing researchers who had worked, or had association with the English Special Hospital system during the 1980's-1990's (see Mason et al 1996, Mason et al 1990, Mercer 1999). That such authors were influenced by their working environments, which were undergoing considerable scrutiny over the period (see earlier in this review) is debatable. Occasionally such work fails to recognise the contribution of research, which has examined specific types of mental illness, and the associations (albeit correlation and not direct cause) between mental disorder and violence.

Mercer (1999) for example relates the lineage of specific testing of incarcerated populations which has produced what he calls:

> 'a growing list of reified pseudo medical abstractions: violence personality disorder aggression etc...research that has to date, yielded at best, inconclusive and contested data'
>
> *(Mercer 1999 p 79)*

Such opinions, unfortunately, tend to negate the contribution to knowledge and understanding which research in this area creates. The fact that research is inconclusive, and contested, does

not necessarily equate to it being of lesser value to the overall body of knowledge, a point often missed in the critical literature in this area. Link and Stueve (1994) have written of the importance of striving to further examine the causal relationship which may exist between mental illness, patient status and violent or illegal behaviour insofar as it informs educational, treatment, and research concerns. They also relate how community programmes, education of the public, and reassurance of the public safety can all result from such work (see Link and Stueve 1994 p 138). Therefore we can see how such work is powerful in terms of its use, Buchanan (1997) has reflected upon clinicians continuing to examine clinical factors in an attempt to help in predicting future behaviour. Here we can see a more constructive approach perhaps, despite the apparent defeatist recognition that there is little evidence from the research conducted, in predictions of violence, to suggest that clinical factors are of value in predicting dangerous behaviour. Buchanan (ibid) however suggests that this is unimportant, especially when dealing with a population where risk of violence is part of providing care. He infers that research in the area of specific examination of variables is important to enable clinicians to be more effective in their predictions:

> 'Forensic Psychiatrists regularly encounter people who are violent only in particular kinds of relationships, and others who are violent only when particular symptoms develop. That these effects are too idiosyncratic and too situation specific to show upon large scale follow up studies is of little concern to the clinician'
>
> *(Buchanan 1997 p 13)*

McClelland (1995, 2001) has discussed the importance of psychosocial clinical risk assessment procedures, and data collection, in relation to forensic nursing practice, illustrating the importance of such work to both client care and reassuring the public of safe practice. Documentation and assessment of history, presenting behaviour, including signs and symptoms of presenting mental disorder are all examined as key to the prediction of future risk (see McClelland 2001 p 14-15) (see Appendix Three). Buchanan (op.cit.) in suggesting how clinicians might improve their clinical risk assessments of violence, points in the direction of a greater focus on clinical variables, such as persecutory beliefs, passivity phenomena and command hallucinations in a way which reflects, 'serial measurements of

behaviour' (Buchanan 1997 p 14), as opposed to simple measures of offending and re-offending. Methodologically, Buchanan (ibid. p 13) suggests, we are drawn to the 'easily measurable' factors, such as socio-demographic status or criminal record. The inference is that research relating to clinical variables will likely bear more fruit in terms of greater understanding and predictive ability.

This research study revolves around the links between particular factors in childhood (physical, sexual and psychological abuse and neglect) and outcomes of violence and mental disorder. However the interplay between variables such as mental disorder violence and criminal behaviour can be complex in itself, without the additional variable of childhood abuse having occurred also. Psychosis, particularly schizophrenia, has been consistently linked to an increased likeliness of offending and violent behaviour in the literature and research (see Hafner and Boker 1973, Taylor 1986, Lindqvist and Allebeck 1990, Wessely and Taylor 1991, Hodgkins 1992, Sellers, Hollin and Howells 1993, Hodgins 1993, Wessely et al 1994, Link and Stueve 1994, Blackburn 1995, Reed 1997, Appleby et al 1999). Hafner and Boker (1973) writing of their study in Germany recognised that certain diagnostic categories were at greater risk for violence, those suffering schizophrenia having a higher risk of violence than the general population. They (ibid.) examined case records of 533 male and female individuals who had killed, 53% having schizophrenia. Taylor (1986) conducting research among life-sentenced prisoners in England, the majority of them murderers, found that 9% had been reported to show schizophrenic symptoms. Lindqvist and Allebeck (1990) traced conviction records of 644 people admitted to hospital for schizophrenia. Whilst crime rates were similar to the general public in this study, violent offences among the schizophrenic group were recorded as four times higher than in the general population. The over representation of those with schizophrenia in prison settings, particularly remand prisons, is apparent in the work of Wessely and Taylor (1991). This work (ibid.), in Brixton remand prison (England) set out to explore the relationship between mental disorder and offending. 203 men were interviewed in this study, over half (121) were recorded as having a psychiatric illness, 90 were regarded as having schizophrenia. Interestingly the study found greater degrees of isolation among the psychiatric group (only 17% of the psychotic group being married, compared to 40% of the non psychotic, and only half of the psychotic group sharing their homes with others, compared

to 80% of the non psychotic group). A further point of interest in this work relates to the fact that more of the non-psychotic men were more likely to have been referred to a child psychiatrist than the psychotic group. Hodgins (1992) examined a large birth cohort of 15,117 people in Stockholm, and found that in men treated for a major mental disorder there was an increased chance (2.5 times) of being convicted of an offence by age 30, and an increased chance (4 times greater) of being convicted of a violent offence, compared to people with no history of psychiatric care or treatment. Interestingly in women the chances of committing a violent offence were 27.5 times greater in a major mental disorder group than in those with no history of psychiatric treatment.

The link between mental disorder and offending owes much to the examination of a captive audience as it were, the prison population, or indeed the study of those within secure psychiatric hospitals, authors tending to conclude that:

> 'overall it is safe to conclude that the general pattern from the empirical studies is that psychiatric problems, including mental illness are common in prison populations'
>
> *(Sellars, Hollin and Howells 1993 p 72)*

The authors (ibid.) similarly comment upon the literature examining criminal behaviour in psychiatric populations, reporting it as higher than in the general population (ibid. p 73). However we can begin to detect some caution in such reviews, with reference to the fact that we may see greater rates of mental illness in prison, but not be aware of its presence at the time of the offence, and of how non-violent offending rates are similar for psychiatric and non-psychiatric populations. A similar cautionary note is provided by Hodgins (1993) who writes of studies of American and Canadian prison inmates during the 1980's and 1990's, and of the high prevalence rates of schizophrenia and major depression, compared to the general population. Her cautionary note relates to the fact that more mentally disordered offenders tend to be arrested, with a clear possibility of bias in records occurring (see Hodgins 1993 p 16). Wessely et al (1994) in the Camberwell Study of crime and schizophrenia (England) conversely noted that when psychiatric patients spend long periods in hospital or prison then

this can have the effect of reducing offending. This study (ibid.), focusing on whether schizophrenia was associated with an increased risk and rate of offending, examined the case register of first contacts over a 20 year period (1964-1984) between those with schizophrenia and the psychiatric services. In examining a range of mental disorders the authors found that rates of convictions for violence and assaults were doubled in schizophrenics. The research began to show the importance of a range of variables influencing the acquisition of a criminal conviction. Schizophrenia was considered as one variable, amongst gender (being male), unemployment, the use of drugs and alcohol, being unmarried as well as early age onset of mental illness. Link and Stueve (1994) whilst advising caution in inferring that people with a mental illness generally commit more violent or illegal acts than other people have concluded, following a wide ranging review of the literature and research, that;

> 'no single study or type of study, conducted thus far definitively demonstrated a causal connection...the robust findings across studies using different designs samples and measures, tips us in favour of the conclusion that there is a causal connection between some types of mental illness and violence'
>
> *(Link and Stueve 1994 p 142)*

Whilst this latter statement may appear to be somewhat contradictory, it is apparent that in examining a wide range of studies regarding mental illness and violent behaviour and/or offending, reviewers find that there does appear to be an elevated figure, especially among particular disorders:

> 'while the relation between the true prevalence of mental disorder and violence is likely to remain elusive, evidence from several sources suggests that some disorders may increase the risk'
>
> *(Blackburn 1995 p 269)*

In progressing toward links between extremities of violent behaviour and links to mental disorder Blackburn (1995 p 270) relates how in Britain mental disorder has been recognised in between 30% and 40% of homicides for much of this century, and during the 1980's about one fifth of those convicted for homicide were determined to be suffering from diminished

responsibility. A more recent study in this area, covering both England and Wales (Appleby et al 1999) examined 718 homicides. 500 psychiatric reports were retrieved in relation to these homicides. In breaking down the diagnosis of these cases the authors (ibid.) reveal that 220 (44%) had a lifetime history of mental disorder, including depression (48 cases), personality disorder (47 cases), and 27 reporting delusions/hallucinations indicative of psychosis. Interestingly, when compared to homicide cases where no mental illness was evident, the victim of the homicide was more likely to be a close relative, either a family member or married to the perpetrator. Reed (1997) attempted to summarise the present state of knowledge from a vast, and growing, literature examining the relationship between mental disorder and violent or dangerous behaviour:

> 'a) The great majority of mentally ill people and those with learning disability present no increased danger to others.
>
> b) The best predictors of future offending among mentally disordered people are the same as those for the rest of the population – previous offending, criminality in the family, poor parenting, etc.
>
> c) People with a severe mental illness, such as schizophrenia or manic-depressive disorder, may present increased risk to others when they have active symptoms.
>
> d) People suffering from severe mental illness who have active symptoms and also misuse drugs or alcohol may present a seriously increased risk to others.
>
> e) People with psychopathic disorder by definition present an increased risk to others.'
>
> *(Reed 1997 p 4)*

The specific 'disorders' discussed earlier alluded to by Blackburn (1995), would appear to be schizophrenia, severe depression and/or psychopathic disorder according to Reed (op.cit.). These disorders, coupled with variables predisposing the general public to violent offending, appear to create an increased likelihood of violent behaviour or offending in the mentally disordered individual.

2.10 Delusions, Hallucinations and Depression

As a symptom of psychosis delusions are thought to be significant in the increased chance of an individual behaving in a violent manner (Taylor 1993, Taylor et al 1994, Blackburn 1995, Mullen, Taylor and Wessely 1995, Taylor et al 1998, Blumenthal and Lavender 2000). Taylor (1993) writes of how there has been a lack of focus in the research examining links between mental disorder and violence, because such examination has not concentrated on schizophrenia or the psychoses. She (ibid.) relates this 'poor focus' on this area because of what she calls 'diagnostic naiveté', and'confusion between medical and legal classifications' (see Taylor 1993 p 63). She attempts to justify the consideration of schizophrenia as the main mental disorder, regarding a link to crime/violent offending, suggesting that those with a label of schizophrenia appear more frequently in criminal or violent populations than people with affective or organic psychoses (ibid p 65). In reporting her previous study of Brixton remand prisoners (England) (see Wessely and Taylor 1991). She outlines how:

> 'the most important clinical differentiator of the psychotic subgroup was not diagnosis, it was delusional drive'
>
> *(Taylor 1993 p 80)*

She (ibid) reports that 46% of the psychotic men in her sample offended in direct response to psychotic symptoms and response to delusions (except for five who were acting on hallucinations), and were more likely to be seriously violent than other psychotic men in her sample. This theme is addressed again by Taylor et al (1994) when, in examining the work of Hafner and Boker (1973), found that they identified that in people with a psychotic illness, who had been homicidal, compared with psychotic patients who had not been violent, significant differences in the prevalence of delusions in these groups occurred. In the schizophrenia group 89% had been deluded at the time of the homicide, compared with 76% of the non-violent patient group (see Taylor et al 1994 p 165 citing Hafner and Boker 1973).

This leads the authors (ibid) to write how:

> 'the excessive association between violence and delusions has also been shown through the indirect evidence that the paranoid subtype of schizophrenia, paranoid states or delusional symptomatology are generally cited as being more commonly associated with violence than other psychotic diagnoses'
>
> *(Taylor 1994 p 165)*

As indicated earlier in this review of the literature Blackburn (1995) recognises that the research points toward schizophrenia as the disorder with greatest risk of violence, and as Taylor et al (1994) recognises particular schizophrenic symptoms as predisposing an individual to violent behaviour it would appear that:

> 'the presence of delusions appears to be the most frequent correlate of violence in psychotic patients'
>
> *(Blackburn 1995 p 271)*

He (ibid.) however advises caution in the extent to which symptoms such as delusions and even paranoid schizophrenia explain violence, recognising how violence in hospitals very often relates to provocation or disputes over food or space rather than psychoticism (see Blackburn 1995 p 271), which is the experience of this researcher also. Blackburn (1995) infers that even in paranoid schizophrenia the research indicates that only small minorities of patients in this category are violent. Mullen, Taylor and Wessely (1995) place delusions and paranoid thought processes within schizophrenia into a group of symptoms which they call 'dangerous symptoms', but as with the work of Blackburn (1995), advise caution commenting on the lack of research addressing a causative link between symptoms and behaviour (see Mullen, Taylor and Wessely 1995 p 383). Taylor's work appears regularly in the journals and textbooks. With regard to the specific examination of schizophrenic symptoms in contributing to our understanding of the links between mental disorder and violence, her work covers both prison populations, as briefly mentioned earlier, as well as clinical forensic populations. Her extensive study of 1,740 Special Hospital patients (see Taylor et al 1998) revealed that over

half (58%) of this population had a diagnosis of functional psychosis, 75% of whom were motivated to offend by their delusions. Blumenthal and Lavender (2000 p 52), despite being critical of the examination of psychiatric diagnoses as a predictor of violence, calling this process unproductive, identify that the examination of the relationship between specific symptoms of mental disorder and violence is a much more fruitful avenue of investigation.

The research related to examination of psychotic symptoms other than delusions and paranoid schizophrenia, and mental illness other than schizophrenia and their link to violent behaviour are less clear however. In the work of Taylor et al (1994), (previously discussed), conclusions were drawn that those with affective disorders had a relatively low level of violence, comparable to the people without illness (see Taylor et al 1994 p 164). Howells (1982) writing of the link between depression and violence, compares it to what he considers the weak association between schizophrenia and the risk of violence in the mentally disordered:

> 'it is important to remember that only a tiny proportion of depressed people are violent, and that alternative hypotheses (to the causal hypotheses) discussed for schizophrenia could equally be applied to depression'
>
> *(Howells 1982 p 172)*

The problem with establishing a link or association between depression and violent or criminal behaviour is almost akin to a chicken and egg argument, or one, which asks the question 'which came first'?:

> 'the offence may have been committed because the offender was depressed, the offenders guilt after the offence may have precipitated the depression, or the offender may have been depressed while committing the crime, but the depression was not a direct cause of their criminal behaviour'
>
> *(Sellars, Hollin and Howells 1993 p 75)*

Whilst there may be a link between specific symptoms of mental disorder and violence the literature and research appears to be inconclusive regarding the extent, or causal nature of the association.

The extent to which the association or the link between specific symptoms of mental disorder and violence is problematic appears to extend to hallucinations also. McNeil (1994) recognises that assaultative behaviour by those suffering hallucinations represents a dramatic example of the co-occurrence of mental disorder and violence (ibid p 183), and of how schizophrenia is often associated with hallucinations (ibid p 184). Despite the 'intuitive plausibility' of hallucinations being associated with violent behaviour McNeil recognises that:

> 'only limited empirical research has been conducted on the topic'
>
> *(McNeil 1994 p 183)*

He concludes his review of this area by suggesting that hallucinations may be related to violence as part of a presentation of acute psychosis, impaired reality testing and poor judgement (see McNeil 1994 p 198). The focus of McNeil's work, whilst apparently reviewing the role of hallucinations in violent behaviour, actually points toward greater consideration of personal situational and clinical factors (ibid. p 188), and the relationship between these factors in contributing to violent behaviour. Hence the importance of the community, or hospital setting, or the hostel in which an individual lives or works. Clearly the unique nature and the importance of previous history, family history, exposure to violence and a range of factors all make more difficult the generalisability of findings between settings. Even in the area of command hallucinations he (ibid.) points to the lack of a clear relationship between assaultative behaviour and hallucinations (McNeil 1994 p 194). However there is some research, which examines the specific nature of command hallucinations, or orders to action hallucinations, which perhaps explain the intuitive belief of hallucinations being linked to violent behaviour, Rogers et al (1990) indicating that amongst forensic in-patients 80% reported compliance with a command, Junginger (1990) finding 39% of his sample of psychiatric in-patients and out-patients complying with commands, and in a further study (Junginger 1995) found 56% of his sample complying with command hallucinations. Mullen, Taylor and Wessely (1995 p 344) concur, indicating that this particular sub category of hallucination, command hallucinations, are the auditory hallucination most associated in the research with the prediction of assaultative behaviour. The extent to which such association

exists however is unclear, at least on the extent of association which might be generalisble across a range of settings.

2.11 Psychopathy/Personality Disorders and Violence

There is a good deal of work associating psychopathy and personality disorder with violence (Hare and Hart 1993, Widiger and Trull 1994, Singleton et al 1998, Wallace et al 1998), and work which is indicative of a greater rate of violent offences being committed, by those in the legal category of psychopath, following release from English Special Hospitals (Tennent and Way 1984). In reviewing the characteristics of psychopathy from the revised psychopathy checklist (PCL-R), (see Hare 1991), Hare and Hart (1993) identify how:

> 'given characteristics of psychopathy... it comes as no surprise that the disorder is implicated in a disproportionate amount of serious repetitive crime and violence'
>
> *(Hare and Hart 1993 p 106)*

These characteristics include amongst others the need for stimulation, pathological lying, lack of remorse or guilt, a parasitic life style, impulsitivity, irresponsibility, criminal versatility and failure to accept responsibility for actions (see Hare and Hart 1993 p 105). The authors (ibid.) cite work (Serin 1991) in prison populations which utilise the PCL-R to assess the presence of psychopathy, finding that all of those diagnosed as such had been convicted of a violent offence, and were more likely to have used a weapon, threats or instrumental aggression than other prisoners. 68% of the other, non-diagnosed, inmates had been convicted of a violent offence. Widiger and Trull (1994) also recognise the long held belief among clinicians of persons with personality disorder constituting a considerable proportion of the violent mentally disordered (ibid. p 203). Their review of the research focuses on the literature examining the high numbers of females, who have been physically or sexually abused in childhood, later receiving diagnoses of borderline personality disorder (BPD). It is within this researchers experience that considerable numbers of female patients in forensic psychiatric settings, with BPD diagnosis, have been witness to, or have experienced a range of abusive histories. Widiger and Trull's work reviewed research indicating that in female BPD patients

forty percent reported a history of sexual abuse, twenty five percent a history of physical abuse, eighteen percent categorized as in the worst abusive group involving severe and prolonged abuse by multiple perpetrators (see Shearer et al 1990). Violence towards self, as associated with diagnosis of BPD, becomes the focus of the authors (op.cit.) examination of the links between the symptoms of BPD and violent behaviour:

> 'research on victims of abuse and on patients with BPD have consistently demonstrated an association of childhood abuse and adult BPD. To the extent that violent abuse provides a risk factor for adult violent behaviour one would expect that a diagnosis of BPD would itself suggest some risk for violent behaviour. Clinical anecdotes of borderline patients have also described the occurrence of impulsive violent anger. However it should be emphasised that the studies of childhood abuse and BPD have not assessed whether this abusive history is related to violent aggressive acts towards others. The focus had instead been on self-destructive suicidal behaviours of borderlines'
>
> *(Widiger and Trull 1994 p 205)*

The interest in the link between personality disorder and violent behaviour, and abuse in childhood/adolescence has received close scrutiny, particularly in terms of it being recontextualised in terms of posttraumatic stress and a series of complex needs, as opposed to a mere diagnostic label. This researcher was recently asked to present findings from this research to an audience of service users and clinicians at a University of Salford conference. The presentation revolved around issues related to previous abuse and diagnosis in the sample under examination in this work, focusing upon those having received a diagnosis of personality disorder (McClelland 2002 unpublished) *(for programme and presentation see Appendix Four A & B)*. The conference debate clearly wrestled with the common belief in the association of violence with those experiencing personality disorder, concluding that the greater predisposition to self-harm should be the focus of attention and treatment, as opposed to violence toward others.

Widiger and Trull (1994) similarly addressed this issue in their concluding remarks concerning the need to recontextualise:

> 'a diagnosis of BPD does not itself suggest aggressive behaviour toward others. It does suggest violent destructive acts towards oneself'
>
> *(Widiger and Trull 1994 p 208)*

The prevalence of personality disorder, particularly in prison populations has been found to be particularly high, 78% among male remand in-mates (Singleton et al 1998). This latter study examined antisocial personality disorder rates among remanded men, finding a rate of 63%, with 49% rates in sentenced men, and 31% in both sentenced and remanded women. Violence is a problem particularly associated with antisocial personality disorder (see Widiger and Trull 1994 p 215). The examination of serious criminal offending and mental disorder has found strong associations between personality disorder and a range of offending categories. Wallace et al (1998) identified that among men personality disorder was associated with 18.7 times the rate of convictions for violent offences and 28.7 times for homicide. This figure was actually higher for women, resulting in 49.6 times as many convictions for violent offences in this study.

However despite the work identifying links between psychopathy and personality disorder and violence there is a strong note of caution running throughout the research and literature generally.

Blackburn (1989, 1995) has argued that even the term 'psychopath' is a contentious one, noting that there is a distinct lack of agreed meaning, and arguing instead for an examination of the causes of violence as a consequence of social learning theory rather than individual tendencies:

> 'social learning theorists, in particular, have maintained that aggression is more a function of specific person-situation interactions than generalized tendencies'
>
> *(Blackburn 1989 p 62)*

Blackburn's criticism of the methodological difficulty, in utilising diagnostic criteria in examining mental disorder and violence and criminality, revolves around vague criteria. This ambiguity over criteria, particularly in personality or behavioural disorders, can lead to a great deal of variation in the recorded rates (see Blackburn 1995 p 267). Despite identifying psychopathy as a risk marker for violence Hart, Hare and Forth (1994) conclude that research overall is:

> 'rather pessimistic about the value of diagnoses of psychopathy in the prediction of criminal or violent behaviour'
>
> *(Hart, Hare and Forth 1994 p 81)*

The reason for this inconsistency in the use of diagnoses may be due to the variation in classification systems utilised in a variety of ways, in a range of settings. The two main classification systems utilised in clinical practice are the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM IV) (American Psychiatric Association 1994), and the International Classification of Diseases and Causes of Death, 10th edition (ICD10) (World Health Organisation 1992).

Burke and Hart (2000) in comparing the two systems regarding personality disorder found some similarity between corresponding categories of disorder, but did not consider the two systems to be parallel, providing the following table as indicative of such inconsistency:

Table 4: Personality Disorders in the DSM-IV and the ICD-10

DSM-IV	ICD-10
Cluster A (odd eccentric)	
Paranoid	Paranoid
Schizoid	Schizoid
Schizotypal	_____
Cluster B (dramatic/erratic/emotional)	
Antisocial	Dissocial
Borderline	Emotionally unstable
	Impulsive type
	Borderline type
Histrionic	Histrionic
Narcissistic	_____
Cluster C (anxious/fearful)	
Avoidant	Anxious
Dependent	Dependent
Obsessive compulsive	Anankastic

_____ = No corresponding personality disorder

(from Burke and Hart 2000 p 65)

The authors (ibid.) further illustrate how the categories of personality disorder, or subtypes, have changed over time, particularly in the DSM series of classifications. They review research, which relates high prevalence rates of personality disorder, but stress that this is usually found in those offenders and forensic patients who also suffer acute mental illness and substance misuse, concluding that the evidence linking violence and personality disorder whilst present, is weak and unclear (Burke and Hart 2000). These factors coupled with the

observation by many authors that the definition of personality disorder and psychopathy (at least in the England and Wales Mental Health Act 1983) is a legal, as opposed to clinical definition, further complicating matters (see Hare and Hart 1993 p 104, Blackburn 1995 p 253, Blumenthal and Lavender 2000 p 65). There needs to be a clear understanding that Hare's (1991) PCL-R is an examination of clinical characteristics associated with psychopathy, and not the legal definition as used in the England and Wales Mental Health Act of 1983. Many of the problems associated with the use of terms such as personality disorder and psychopathy appear to stem from the pejorative way in which the label has been used and the subsequent effect this has had on the views of many as to treatability. The construct of both disorders are useful in determining risk (see Blumenthal and Lavender 2000 p 67) but contain within them many criminal features and descriptors, making the link between the disorders and violence almost inevitable in many ways. This returns us to the observation of Hare and Hart (1993), at the beginning of this section, that it is unsurprising how the disorder (psychopathy) is implicated in much of the crime and violence we see around us. However, the methodological limitations, which are a part of such work when examining relationships between crime, violence and personality disorders, psychopathy and/or mental illness, should pull us away from such simplistic belief in the cause-effect rationale of such links or associations. Shah (1993) brings this scepticism into focus, touching upon what has been briefly reviewed within this section:

> 'because what is classified are the disorders that people have – not the people – there typically are many within this category variations among individuals given the same diagnosis... thus one is hard pressed to provide meaningful answers to such questions as: was the criminal or violent act the result of, and caused by the disorder?: Did it reflect some long standing personality traits – perhaps exacerbated by the disorder... stated differently, the demonstration of a statistical relationship (correlation) does not establish a causal link'
>
> *(Shah 1993 p 307)*

Despite the greater statistical linkages, and intuitive associations between personality disorder and psychopathy, and violent offending, the same weaknesses as those in linking mental disorder and violent offending appear to be present.

2.12 Obstacles to Establishing Association between Mental Disorder or Personality Disorder/Psychopathy and Violent Behaviour and Offending

Some of the research and literature previously discussed within this Chapter can be seen as a review of the obstacles and confounds to establishing a link between mental disorder, or psychopathy/personality disorder and violent behaviour or offending.

I have briefly mentioned, on more than one occasion, the difficulty in establishing causality, as opposed to statistical associations, but other areas are also held up to be inherently problematic in this area of work. Many authors have criticised the measure of violence utilised in such research, which are usually convictions for violent offences or arrest rates (Hodgins 1993, Link and Stueve 1994, Mullen, Taylor and Wessely 1995, Blackburn 1995, Buchanan 1997, Wessely 1997). Hodgins (1993 p 16) for example writes of the bias concerning greater numbers of mentally disordered offenders being arrested than non disordered people, because of them being easier to detect, conversely she writes of the possibility of under representation in the figures when such people are excused for their behaviour. On this latter point Link and Stueve (1994) outlined how more people are now being excused for their behaviour, and of how more, and 'greater numbers of behaviours, including violent and illegal behaviours are coming under the purview of psychiatrists' (Link and Stueve 1994 p 139). Hence there are more people who might be predisposed to violence or illegal behaviour in these populations. The authors (ibid.) believe that arrest rate differentials tell us less about the associations between mental illness and criminal behaviour and more about the associations between mental illness and the arrest process itself. This process may include what Mullen, Taylor and Wessely (1995 p 332) called a systemic bias, the mere presence of psychosis increasing the chances of an individual's arrest. The authors (ibid. p 333) also refer to a 'cycle of re-offending', which offender patients find themselves in. This occurs as a consequence of large-scale hospital closure, and a subsequent escalation of arrests for those ex psychiatric patients who have one prior arrest. Those with a previous conviction are therefore over-represented in the reduced in-patient populations of psychiatric hospitals. This may seem a circuitous route to explaining the problems associated with arrest rates being used to verify an association between mental illness and violent offending, but Blackburn (1995 p 265) takes the complexity of establishing a relationship even further. He outlines many significant

methodological problems, including the identification of mental disorder, the clinical orientation of the researcher and questionable representativeness of samples. He too relates what he considers to be the problems associated with arrest rates and 'true' rates of mental disorder. This latter point is enlarged upon by Wessely (1997) who comments upon the contradiction in the survey studies saying one thing (guided by official arrest figures), and psychiatrists working with smaller sample studies involved in what he terms 'more detailed research' (ibid. p9) saying another. Wessely accounts for this difference by what he calls the 'dark figure' in crime surveys, or the:

> 'massive shrinkage in the criminal process that occurs from all those who commit crimes to all those who end up with official criminal records'
>
> *(Wessely 1997 p 9)*

As discussed earlier in this review, Wessely comments upon people with schizophrenia who are more likely to be caught for crimes give themselves up, and of how:

> 'these people are less likely to be prosecuted, convicted or imprisoned. That is obviously desirable on humanitarian grounds, but a problem for reliable population based studies'
>
> *(Wessley 1997 p 9)*

It is unfortunate perhaps that the most commonly used measure of violent behaviour is conviction for a violent offence (Buchanan 1997 p 12). Unfortunate in the sense that these figures appear to be beset by so many problems in terms of establishing an accurate association between mental disorder and violent offending.

There would also appear to be a belief, within some of the literature, that the focus has been too fixed on addressing the role of one variable, be it mental disorder or personality disorder, and ignoring a large range of other situational and environmental predisposing factors to violence (see Hollin and Howells 1989, Sellars, Howells and Hollin 1993, McNeil 1994, Wessely 1997, Blumenthal and Lavender 2000). Following a brief review of some of the

sociological accounts of violence, citing the work of Wolfgang and Ferracuti (1967), where violent subcultures exist and where violence is considered the norm, providing key avenues for the young to achieve status, Hollin and Howells (1989 p 19) argue for greater consideration of social, environmental and organic antecedents, to both violence and schizophrenia. Sellars, Hollin and Howells (1993 p 75) suggest that rather than seeing schizophrenia as a cause of violent behaviour, the schizophrenia and violence are best seen as the interactive consequences of common adverse environmental conditions. McNeil (1994 p 188) has called these factors; 'personal situational and clinical factors. Personal factors within this scheme include diagnosis, acute symptomatology, the course of the illness and personal history (including previous violence, abuse, substance misuse). The situational factors relate to availability of victims, weaponry, family environment, place of residence. The clinician factors revolve around the accuracy of the clinician in identifying violence and the nature of any clinical intervention undertaken (see McNeil 1994 p 189). Blumenthal and Lavender (2000) whilst considering base rates of violence as extremely low among the mentally disordered, review the literature surrounding demographic factors predictive of violence reminding the clinician that:

> 'psychological discourses have a tendency to conceptualise human experience from a solely individualistic perspective and to ignore the social contextual dimension'
>
> *(Blumenthal and Lavender 2000 p 42)*

Whilst the authors (ibid. p 42) relate that demographic factors such as unemployment, young age, male gender, low socio-economic status and poor education contribute to violence, they remain as correlates of violence, the lack of research indicating whether or not such factors are causal confounds definitive answers to this question. In discussing the social context the authors (ibid. p 69) relate, among other areas, the importance of neighbourhood in which an individual resides, the fact that mentally disordered people are at high risk for victimisation, and of how the majority of violence perpetrated by those with psychotic disorder is against relatives.

These areas, the authors suggest, redress the balance to the context in which violence occurs:

> 'mental disorder is an interpersonal and contextual matter, and not simply a neurological or clinical one'
>
> *(Blumenthal and Lavender 2000 p 70)*

In pursuing such a focus in the research, that social and environmental factors were equally, if not more, important than clinical factors we are almost drawn full circle to the conclusion put forward by Wessely (1997) following his Camberwell study (briefly discussed earlier in this review):

> 'the strongest predictors of criminal behaviour in people with schizophrenia were gender, ethnicity, age of onset and previous offending. No amount of psychiatric care and supervision can alter these associations'
>
> *(Wessely 1997 p 11)*

The point is well made, confirming the observations of Blumenthal and Lavender (2000), who recognise that predictors of criminal behaviour in schizophrenics are likely to be much the same in the general public, and are thus deserving of a greater level of address within the research and literature generally.

There are a range of further confounds, and obstacles to accuracy in establishing associations between a range of mental, and personality disorders and criminal behaviour and violence. The over reliance on case records in many studies make researchers dependent upon records of mental states which are expected to be comprehensive, and of records of violence and offending links which are similarly expected to be accurate (see Mullen, Taylor and Wessely 1995 p 335). Researchers are placed in the position of having to ignore omissions, or lack of detail regarding links between the focus of critique, in well respected works such as the study by Swanson et al (1990). This latter study is considered to be very comprehensive, basing its examination of links between psychosis and violence in a large community sample (10,000 residents of Baltimore in the USA), it is considered to be a good example of an

epidemiological catchment area study. As discussed earlier (Wessely 1997, Blumenthal and Lavender 2000) violence in the study (op.cit.) was associated unsurprisingly with factors such as male gender, young age and low socio-economic status. But 8% of people with schizophrenia reported violence over a 12-month period, compared to 2% among the general population without a psychiatric diagnosis. However Taylor et al (1994 p 164) has suggested that differential reporting of violence in Swanson et al's (1990) study may have been evident, further suggesting that the rates of violence in the healthy sample may have been under reported , and that people with psychotic illness are much less likely to conceal such activity, leading to obvious exaggeration of the association between psychosis and violence. Taylor had previously commented upon the differences in true rates and recorded rates a year previous to her critique of Swanson's work. She illustrates how decisions made in referring a person to health care or criminal justice facilities are often 'arbitrary', creating havoc for a researchers sampling procedures (Taylor 1993 p 65). She reports on how violent behaviour in those who are mentally ill often results in direct admission to hospital as opposed to the criminal justice system, and of the consistent appearance of psychotic offenders in both systems:

> 'psychotic offenders appear in both health and criminal justice systems, how far exclusively in one or the other remains uncertain'
>
> *(Taylor 1993 p 65)*

A further confounding factor in attempting to establish an association between mental illness and crime is the fact that a patient may be experiencing a number of illnesses, which can affect responsibility for actions (ibid. p 65). Many of the works discussed within this section of the review have pointed toward the methodological problems which beset researchers attempting to establish a relationship between violence and mental disorder, arrest rates, records, sampling procedures and a range of illnesses being experienced by an individual at one time are some of the areas which have been briefly discussed. Blumenthal and Lavender (2000 p 20-21) write of these areas as being particularly problematic, in what serves as a useful conclusion to this section. They (ibid.) write of how the narrow range of predictors, (diagnosis, substance abuse and a history of violence), are failing to address the complex

causes of violence. This is perhaps a case of researchers being drawn to the 'easily measurable' as previously discussed in this review, and avoiding the complex environmental and situational predictors. They (ibid.) write of 'weak criterion variables,(arrest and conviction rates)' for instance, failing to address behaviour which is non-violent, which may still induce fear, as well a failing to recognise that referral to either criminal justice or health settings can be complex and even arbitrary. A further methodological problem related by the authors concerns constricted validation samples. It is suggested that the participants of studies tend to be highly selected, forensic mental health populations for example are likely to be admitted on the basis of violent or aggressive behaviour, unmanageable in generic psychiatric hospitals. This would clearly have the consequent effect of limiting the generalisability of such samples. The authors reflect upon the different factors affecting base rates of violence in samples drawn from the structured environment of the institution, and from community based research samples. Finally the authors relate their concerns over what they call 'unsynchronised research efforts', a lack of communication and coordination of research efforts. This leads to idiosyncratic definitions, which in turn makes it difficult to compare findings. This would appear to be not an overly dissimilar scenario to the research efforts in childhood abuse and later violent offending discussed earlier in this review, where a range of definitions of abuse leads to the difficulty in comparing findings.

2.13 Childhood Abuse and Adult Psychopathology – Mediating Factors

One of the major methodological difficulties involved in research attempting to examine links between mental disorder and violent behaviour, mental disorder and violent offending, personality disorder and violence and/or violent offending, or indeed childhood abuse and later psychopathology, as it is most associated with offending or violence, are problems associated with comparing findings. Grubin (1997), in writing of risk prediction in serious sex offenders debates the common belief that if we know enough of an individuals past we may be able to predict their future with greater accuracy (ibid. p 17). Grubin criticises the consequent generation of risk assessment algorithms, as 'desktop prediction of risk'. He (ibid.) considers this problematic, in its reliance upon static historical data. Grubin (1997 p 18) writes of the difficulty in generalizing findings from one population to another, such actuarial studies being

empirically driven, and having minimal theoretical foundation. Whilst Grubin's reference here is to the risk of offending in sex offenders the analogy to prison studies, hospital studies and community samples as previously discussed in this review is clear. Grubin goes on to criticise the static historical data usually utilised in such work, ignoring changes in circumstance, treatment or maturity (ibid. p 8).

The importance of how changes in situation, circumstances, and environment can effect the range of associations which are the focus of this research has been discussed earlier in this review. With regard to childhood physical and sexual abuse and the development of later psychopathology many have recognised the complex mediating effect of developmental arrest, situational environment, as well as significant mediating factors such as severity of abuse suffered (Marshall and Barbaree 1989, Rummell and Hansen 1993, Downs and Miller 1998, Millar and Lisak 1999, Blumenthal and Lavender 2000). Marshall and Barbaree (1989) for instance conceived a theory of learning based model of sexual aggression in adults, which integrates biological endowment, childhood experience, the socio-cultural environmental influences as well as situational factors such as intoxication, and circumstance which could include easy access to victims or a lack of constraints (ibid. p 212).

The authors write of how severe and inconsistent discipline from parents, sexual abuse of the child and siblings is framed within their model:

> 'exposure to these types of parental styles clearly ill prepares the growing boy to acquire the constraints and skills necessary to function appropriately in adult sexual relations'
>
> *(Marshall and Barbaree 1989 p 214)*

These developmental problems associated with adverse environmental conditions and abnormal discipline procedures would therefore create maladaptive behaviour patterns in the adult having experienced them. This is clearly a model after Bandura (1973), a social learning model where experience and observation are key to future behaviour. Mullen (1993) relates the increased rates of mental disorders amongst these with a history of sexual abuse, including

depression, eating disorders and substance misuse (if indeed the latter can be considered a mental disorder). However he (ibid. p 429) recognizes that such abuse often emerges from a complex matrix of social and family disadvantage. Mullen (ibid) concurs with Marshall and Barbaree (1989) and Bandura (1973), in identifying the importance of developmental stress in those who have experienced childhood sexual abuse, risking an emerging sexual identity, damaging self esteem and undermining a childs sense of the world. It may even be that the long term effects of childhood sexual abuse on mental health are secondary to the influence of the disruption to the childs development in terms of clinical consideration (see Mullen 1993 p430). Thus the abuse is not causal of the later mental disorder, but plays a considerable role in removing the protection afforded by being involved in supportive relationships as a child. Mullen's matrix of social and family disadvantage can also be seen in the work of Millar and Lisak (1999). In examining childhood abuse and personality disorder symptoms in college males the authors (ibid. p642) found that abuse histories were associated with greater levels of adult symptomatology. Unsurprisingly, considering the literature previously discussed in this review such histories occurred in significant numbers of those with borderline personality disorder symptom ratings.

The family environment is considered to be key in this study however (ibid.), particular in relation to the severity of abuse suffered and the mediating role of poor relationships and disruptive environment:

> 'the findings that men with both types of abuse came from homes with poorer relationships and more disruption than men in other groups, supports the notion that home environments that are associated in some way with both types of abuse are more pathogenic in general'
>
> *(Millar and Lisak 1999 p653)*

The complexity in this latter research would appear to relate to both the environment, and to the severity (physical and sexual abuse) of the abuse experienced, as it mediates later psychopathology.

Severity of abuse experienced by a child, as a mediating factor in later rates of psychopathology is consistently discussed within the literature and research in this area, suggesting an association which is related to the developmental distress and trauma outlined by Marshall and Barbaree (1989), Mullen (1993), and numerous authors who recognise the importance of developmental psychology and developmental arrest in this area.

Downs and Miller (1998) examined the relationship between experiences of parental violence in childhood and psychiatric symptomatology in a sample of 472 adult women. They determined severity of violence in both parents as follows:

> ' 0 = Victimisation
> 1 = Verbal aggression
> 2 = Maximum of moderate violence, verbal aggression may or may not be present
> 3 = Maximum of severe violence, verbal aggression/moderate violence may or may not be present '

(Downs and Miller 1998 p 443)

Amongst a range of predictor variables including alcohol problems, parental alcohol problems and childhood socio-economic conditions the authors found that severity of father to daughter abuse predicted adult psychiatric symptomatology (ibid. p438). Browne and Herbert's (1997 p 10) severity of maltreatment classification (see Appendix Two) is a further attempt to assist the clinician in classifying incidents. However even in providing such assistance the authors (ibid. p 9) recognize that the co-existence of some, or all, forms of maltreatment, differing in frequency direction and force, and the added difficulty in quantifying psychological or emotional abuse, contributes heavily to the paucity of literature in the area of severity. Mullen (1993) has similarly found, in examining childhood sexual abuse and the development of mental disorders, that the more severe and intrusive the childhood sexual abuse the stronger the association to adult psychopathology (ibid. p 430). Interestingly Mullen also comments on how the impact of such abuse will vary, according to both severity and the stage of the child's development when the abuse occurs. In the same year Mullen et al (1993) made explicit the nature of how severity impacts upon greater rates of psychopathology. The authors (ibid.) set out to establish the relationship between reported childhood sexual abuse and mental health in

a random community sample of adult women. Women, who reported childhood sexual abuse had significantly higher levels of psychopathology, were more likely to have received psychiatric treatment (22% vs. 10%) and were more likely to have had psychiatric admissions than the non-abused control group. In terms of severity of abuse suffered and psychopathology the authors found that:

> 'the highest scores (mean scores) were found in those who had been exposed to abuse involving genital contact or actual intercourse'
>
> *(Mullen et al 1993 p 723)*

For those who had been severely abused, psychiatric admission was five times more likely in those who had experienced genital contact and sixteen times more for victims of abuse involving intercourse (ibid. p 727). Rummell and Hansen (1993) similarly recognised the importance of severity of abuse as a moderating factor in examining the long-term consequences of childhood physical abuse, particularly multiple forms of maltreatment (ibid. p 74). The rates of depression and self destructive behaviour were higher in adulthood as reported in a college sample of both men and women where there had been frequent and severe sexual abuse, with longer duration, in childhood (see Boudewyn and Liem 1995).

Blumenthal and Lavender (2000) remind us of how more is required than a simple statement of whether an individual has a history of violence in order to predict future behaviour (ibid. p 46). They write of the importance of examining stimulus conditions, the nature of the violence, the type of victims and the contextual and environmental triggers. Similarly with attempting to establish links between childhood abuse and later psychopathology the stimulus conditions of frequency duration and severity, as well as the type of abuse suffered, require detailed examination. It is worth remembering however that not all those who have been abused in childhood will suffer later mental disorder or become abusers themselves, as Mullen (1993 p 431) states, 'abuse is not destiny'. If abuse can be addressed at the time of the abuse having occurred then the clinician or healthcare worker is able to intervene, in an informed way, to prevent developmental disruption. If examined at a later stage then the clinician or healthcare worker can, in an informed way, intervene in, or address the abuse trauma.

Chapter Three: Methodology

3:0 Philosophical Approach to Methodology

In an attempt to rationalise identity, professional standpoint and ideology in relation to the research, this researcher examined his strategic approach to learning. It was anticipated that such a reflexive process would enable further exploration of my learning strengths and gaps. Kolb (1984) has linked theory to practice and developed a 'cycle' to describe these phenomena. The Kolb cycle infers that learning processes undergo transitions involving Concrete Experience (feelings), Reflective Observation (watching) Abstract Conceptualisation (thinking) and Active Experimentation (doing). In utilising this model to evaluate the researcher's learning style it was anticipated that an established or preferred way of learning would indicate this researchers preferred reasoning strategies (inductive or deductive) and hence the research style. The knowledge would assist in the development of a methodological approach to this research. Any gaps identified in the researchers learning style could then be modified and capitalised upon.

Honey and Mumford (1992) developed learning styles inventory. This researcher was subjected to a styles assessment, administered at John Moores University, Liverpool, England. This researcher was scored and the test determined a learning style of diverger. Thus this researcher, according to the adaptation of Kolb's Learning Styles inventory, combines Concrete Experience (CE) and Reflective Observation (RO) attributes as a preferred style. The CE mode of learning has a tendency to be experience based and feelings based, similarly this contribution reflects a people oriented approach, and someone who is comfortable with ambiguity. The RO mode is tentative, impartial, and reflective, preferring the role of observation. The combination of CE and RO placed this researcher into a quadrant of the model titled Diverger. Wilson (1996) has explored this style identifying particular strengths in imaginative ability, and ability to generate ideas (brainstorming sessions). The style is further characteristic of those individuals from humanities and liberal arts backgrounds. Interestingly this researcher scored lowest on the attribute of Active Experimentation (AE), an approach to learning which relies heavily on experimentation, characterised by individuals with laboratory

education who engage in practical application in subjects such as engineering and the sciences (from Wilson 1996).

Through extending the work of Kolb to further examine strategies of learners and researchers, we can begin to better focus on an analysis of choice of methodology. In examining reasoning and links to the cycle McClelland and Yolles (1997) differentiated research approaches broadly into those that are deductive and those that are inductive. In relating this division of research approach to Kolb's learning cycle McClelland and Yolles (1997) have suggested that the deductive approaches can be seen to correspond to those styles on the left hand side of the cycle and the inductive approaches to those on the right hand side. Polit and Hungler (1995 p 9) have defined these types of logical reasoning;

> 'inductive reasoning is the process of developing generalisations from specific observations',

And;

> 'Deductive reasoning is the process of developing specific predictions from general principles'
>
> *(Polit and Hungler 1995 p 9)*

Deductive reasoning /deductivism is linked to empiricism, and can be seen as being concerned with rationality and testing theories through hypotheses, a positivist view. The hypothetico–deductive tradition (that scientific knowledge is preceded by the deductive tradition) is intimately related to positivism and causality. Inductivism therefore, as Polit and Hungler (1995) have indicated, is the reverse of deductivism in that it seeks to construct explanation and theories about observations from an empirical world. The theory is the outcome of induction. The models utilised within inductive reasoning processes rely on stimulus, experience, response, interpretation, meaning and action.

The researchers learning style and research style as determined within the scored inventory lay on the right hand side of Kolb's cycle, an inductive approach to learning and research,

according to McClelland and Yolles (1997). This is perhaps unsurprising, reflecting this researchers professional background as a nurse with mental health nursing as his area of specialty. Here the training and preparation, and post registration educational development is underpinned by holism. Carper (1978) illustrates well the holistic epistemology. Carper (1978) examined a typology of patterns of knowing in nursing practice, empirics, aesthetics, ethics and personal knowledge. Despite this researchers schooling in such encompassing holistic approaches to inquiry and research, there are many authors who have recognised the hegemonic control exercised over nurses and nursing research by professions such as medicine. Playle (1995) whilst acknowledging that nursing and nurse education has been more heavily influenced in latter years by humanistic philosophy argues that:

> 'Implicit adoption of notions of science, based in a positivistic paradigm gives rise to conflicts with a humanistic philosophy. It is contended that nursing has inherited a legacy of positivism which promotes objectivity and reductionism and which excludes subjective meaning and the personal from the research process. In part this has been due to the powerful influence of the medical hegemony, which has defined the nature of legitimate knowledge and controlled nursing research through the gate keeping function of Doctors'.
>
> *(Playle 1995 p 979)*

He goes further in the same article, arguing that nursing has increasingly striven toward increasing its scientific status, and in doing so:

> 'nursing has become infused with a positivistic ideology based on a natural science model of research'
>
> *(Playle 1995 p 981)*

This tradition of positivistic quantitative research, emerging from the medical model and research methods of natural science has not necessarily been developed within the field of nursing itself, as Duffy (1985) illustrated:

> 'Nursing quantitative research is based upon theories borrowed from other disciplines or attained by a pre-scientific method-intuition or vision'
>
> *(Duffy 1985 p 231)*

Thus we have a picture and tradition of nurses wrestling with a positivistic dominance. Nurses are simultaneously attempting to move away from a philosophical position which has been influenced so heavily by professional groups predisposed to linear relationships, and reductionist approaches, to one which acknowledges the importance of the real experience of people in our care. Cutcliffe (1998) has provided an interesting critique of this ambiguity, reflecting how many nurse researchers have readily accepted the biomedical model:

> 'Thus positivistic philosophies, quantitative methods and the hegemony of randomised control trial designs can be seen throughout nursing research reports'
>
> *(Cutcliffe 1998 p 257)*

McKenna (1997) [1] illustrates the dissonance between 'know that' and 'know how' knowledge. Cutcliffe (ibid.) however contends that nursing students are provided with research concerned with 'know that' knowledge, yet practice dictates the need for research concerned with 'know how' knowledge. Hence research/theory/practice/ gaps are perpetuated. This research has illustrated within Chapter Two how many of the nurse subjects of this study have been witness to, and part of, significant educational shifts in nursing over the last two decades. Thus nurses who may have been schooled in a biomedical positivistic philosophy of research are actually embracing new paradigms of inquiry, which examine the lived experience of clients and new approaches to our basic beliefs, particularly quantitative paradigms. Thus nurses are increasingly drawn toward an examination of discussing and using alternative paradigms and ideas which focus our inquiry on a number of areas including, what is the nature of knowledge

or reality? (ontology), what is the relationship between the researcher and the knowledge? (epistemology) and how should the inquirer go about finding out knowledge? (methodology) (see Guba 1990). Cutcliffe (1998) frames this search for a new paradigm of nursing research within the work of Patricia Benner (1984). In writing of Benner's work Cutcliffe (ibid) relates how:

> 'She asserts that nursing practice provides a rich source of knowledge, and that the knowledge embedded in clinical expertise and the subsequent theory produced from this knowledge are central to the advancement of nursing practice and the development of nursing science'
>
> *(Cutcliffe 1998 p 258)*

An examination of the usefulness and appropriateness of paradigms related to quantitative and qualitative approaches was therefore undertaken to further examine concepts of clinical expertise within this research.

3:1 Quantitative Approaches

Polit and Hungler (1995) maintain that scientific research is the most sophisticated method of acquiring knowledge, asserting its superior role to traditional custom and practice and heritage in nursing practice. The authors contend that its capacity for self-evaluation, its use of checks and balances minimise both bias and the effect of the researcher on conclusions made. They describe clearly the characteristics of a scientific approach, movement in an orderly and systematic fashion, through defining a problem to designing a study, collecting the data to solution of the problem. This enables the researcher to maintain 'order and control' over the whole process. (Polit and Hungler 1995 p 9). They further illustrate the importance of control, minimising confounding factors, empirical inquiry, ensuring objectivity, generalisability, determinism or cause and effect relationships and explanation of interrelated phenomena. Such approaches tend to be quantitative in nature, and research using such an approach generally adheres to the following 'hard science rules'.

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[1] McKenna (1997) .....Cited in Cutcliffe

The approach will;

- Focus on a small number of specific concepts
- Begins with preconceptions of how hunches are interrelated
- Uses structured procedures and formal instruments
- Collects information under conditions of control
- Emphasises objectivity in analysis
- Analyses through use of statistical procedures

(Polit and Hungler 1995 p 15)

This positivist approach has at its core concepts of 'objectivity truth reductionism and empiricism' (Playle1995 p 981). Duffy (1985) illustrated how the natural sciences model a positivist philosophy, and are primarily concerned with observations of phenomena, and of how positivism is a deductive process of knowledge attainment which;

> 'Seeks to verify facts and causal relationships stated in existing theories'

(Duffy 1985 p 226)

He further suggests that 'true experiment' is at the core of a positivistic philosophy, defining this as follows;

> 'The goal (of the true experiment) is the establishment of general laws, common to the phenomenon regardless of the setting. To reach this goal, this methodology isolates and reduces aspects (or variables) of human beings to object status ...the observations are quantified and analysed to determine statistical probabilities or the certainty of a particular outcome.'

(Duffy 1985 p 226)

The search for an identifiable truth is clearly the focus of such an approach and would obviously influence the chosen methodology. The worldview of a researcher is also heavily influenced by such an approach, often recognised to be emergent from a realist ontology, one which Guba and Lincoln (1994) have suggested is often called;

> 'naïve realism. An apprehendable reality is assumed to exist, driven by immutable natural laws and mechanisms. Knowledge of the 'way things are' is conventially summarised in the form of time and context free generalizations, some of which take the form of cause effect laws...the basic posture of the paradigm is argued to be both reductionist and deterministic'
>
> *(Guba and Lincoln 1994 p 109)*

Some authors infer that the falsification of theory is the only way to achieve scientific revolution. Popper (1981) writing of progress in science has suggested that;

> 'we do not discover new facts or new effects by copying them, or by inferring them inductively from observation... we use, rather, the method of trial and elimination of error'
>
> *(Popper 1981 p 90)*

This was suggesting that man must continually try out their hypotheses through trial and error elimination. In generating the resultant theory, Lakatos (1981) in reference to this work of Popper has suggested that to qualify as scientific such theory must;

> 'predict facts which are novel, that is unexpected in the light of previous knowledge'
>
> *(Lakatos 1981 p 13)*

In support of such methodological approaches a strong literature has emerged in nursing and healthcare examining and illustrating useful quantitative designs which are relevant to nursing and allied professional groups. The Journal 'Nursing Times Research' (NT Research) is one example of such literature, and two articles from this journal provide a concise summary of

this overview of positivist / quantitative approaches to research. White and Brooker (1997) when writing of survey methodology indicate how the well designed survey can produce considerable amounts of detailed data, lending itself to quantitative analysis. They also contend that previous epistemological criticism of survey revolved around it being inherently positivist, and of how in recent times positivism;

> ' has become little more than a term of abuse'
>
> *(White and Brooker 1997 p 167)*

White and Brooker (ibid.) are clearly advising caution in the dismissive attitude of many nurses and healthcare workers toward a longstanding and clearly useful methodological approach. Seers and Crichton (2001) are more specific in guiding the would be nurse researcher through quantitative designs of relevance (to nursing). The authors in a very concise way provide the reader with an understanding of quantitative research and its concern with populations, patterns in such populations, the efficacy of interventions, observational study, necessary sampling methods, cross sectional survey, as well as cohort and longitudinal study. Interestingly, and despite the underpinning philosophy of 'one truth' implied within the use of such an approach, the article is unbiased and does not in any way suggest the exclusive use of positivistic methods.

3:2 Qualitative Approaches

In the same way as they described the general principles of a quantitative approach to research Polit and Hungler (1995) also described the underlying principles of a qualitative approach which generally;

- Attempts to understand the entirety of a phenomenon rather than focus on specific concepts
- Has few preconceived hunches, stresses the importance of peoples interpretation of events and circumstances rather than the researchers interpretation

- Collects information without formal structured instruments
- Does not attempt to control the context of the research but, rather, attempts to capture it, in its entirety
- Attempts to capitalize on the subjective as a means for understanding and interpreting human experiences
- Analyses narrative information in an organized, but intuitive fashion.'

(Polit and Hungler 1995 p 16)

This clearly illustrates the key differences between the quantitative and qualitative approaches. Bailey (1997) cites Schwandt (1994 p 18) in describing the goal of the qualitative research paradigm as;

> 'to provide a research methodology for understanding the complex world of lived experience from the point of view of those who live in it '

(Schwandt 1994 p 18)

The focus on meaning, understanding and lived experience is echoed by Guba and Lincoln (1994 p 106) who contend that human behaviour cannot be understood without reference to such phenomena. Such an approach is often described as humanistic in nature and Playle (1995 p 980) amongst others, have written of healthcare shifts, from an illness cure model to more person centred individualistic approaches. In contrast to the pure observation of phenomena in the natural sciences Duffy (1985 p 226) illustrates the additional challenge placed upon the social sciences to understand the meaning of the phenomena. She goes further in describing how 'phenomenology' and inductive processes generate theory from facts obtained within the natural setting, an inductive reasoning process described earlier in this section of the research.

Oiler Boyd (1993) illustrates well the use of a phenomenological perspective as a philosophical framework. She describes how qualitative methods derive from perspectives

developed in phenomenology, perspectives such as symbolic interactionism, naturalistic behaviourism, ethnomethodology, and of the integrating theme as the concept of *verstehen.*

She cites Patton (1980) in defining the verstehen tradition as:

> 'understanding that focuses on the meaning of human behaviour, the context of social interaction, an empathetic understanding based on subjective experience and the connection between subjective states and behaviour'
>
> *(Oiler Boyd 1993 p 77)*

The concept of verstehen is acceptable to the majority of qualitative researchers who may not accept a 'phenomenologist' approach literally, but will draw upon phenomenological perspectives. Phenomenology has been defined by Polit and Hungler (1995) as;

> 'an approach to human inquiry that emphasizes the complexity of human experience and the need to study that experience holistically as it is actually lived'
>
> *(Polit and Hungler 1995 p 649)*

Guba and Lincoln (1994 p 106) have illustrated such complexity in an inquiry a researcher may undertake, in the *etic/emic* dilemma. The etic perspective (outsider view of a cultural group) is brought to bear on an inquiry. This etic perspective, which may be hypotheses to be tested, may have little or no meaning within the emic perspective (the way members of a cultural group view themselves, an insider view). Guba and Lincoln (1994) suggest that qualitative data are useful for revealing and 'uncovering' emic views. Freshwater and Rolfe (2001) contend that much of nursing practice takes place in 'swampy lowlands' (attributed to Schon 1987), a place where messy confusing and ambiguous problems present. They support a picture of nursing practice as:

> 'complex, context dependent, and not amenable to simple research based prescriptions'
>
> *(Freshwater and Rolfe 2001 p 527)*

In summary the qualitative researcher is likely to have a very different relationship with informants and data than that of quantitative researcher. This relationship is likely

characterised by a researcher immersed in the subjective condition or state of his/her sample, with a flexible approach to data collection. The approach will likely utilise a methodology, which does not purport to be objective, but will likely discuss openly issues of bias, reactivity and involvement in processes such as participant observation, knowledge of subjects, deconstruction and reconstruction and content analysis. Thus the researcher will believe the research to be more valid within its methodology, being less concerned with reliability, or the degree of consistency with which a particular instrument measures an attribute.

3:3 A Critique of Quantitative and Qualitative Approaches

The difficulty in utilising one methodological paradigm over another is illustrated well by Popper (1981) who despite making reference to the natural sciences clearly illustrates the importance of change and how it occurs;

> 'very similar organisms may sometimes respond in very different ways to some new environmental challenge'
>
> *(Popper 1981 p 82)*

Popper (1981) reminds us of how new structures can alter environmental situations, and of how new elements of the environment can become relevant, new pressures challenges and problems can thus arise within an organism. He contends that it is in this way that science progresses. In providing a critique of positivism Giddens (1979) reminds us of how empirical observation in isolation can be problematic. The new 'environmental challenges' as discussed by Popper may be pushing positivists to consider alternative paradigms perhaps? Giddens (ibid.) reminds the reader of how;

> 'scientific knowledge is built on shifting sand'
>
> *(Giddens 1979 p 262)*

There are similar discussions concerning notions of 'scientific maturity' as being closely linked to the increase in the degree of quantification used within a given field (Guba and Lincoln, 1994, p 106). They accuse quantitative data of 'context stripping', and of how

statistically meaningful generalizations have no relevance to individual cases. Guba and Lincoln further critique the positivist epistemology because of assumptions that:

> 'investigator and investigated 'object' are assumed to be independent entities, and the investigator to be capable of studying the object without influencing it or being influenced by ... inquiry takes place as though a one way mirror, replicable findings are in fact 'true'
>
> *(Guba and Lincoln 1994 p 110)*

It is this detachment which gives rise to critique of quantitative methodology, particularly in subjects such as nursing, reliant as it is on 'personal perception, personal experience and personal knowledge' (Holloway and Fullbrook, 2001 p 539). Cutcliffe (1998) has taken this critique of quantitative methodology in nursing one step further in focusing on mental health /psychiatric nursing. He denies completely the usefulness of quantitative approaches in this branch of nursing;

> 'Where some practice may be unmeasurable and even invisible, e.g. ways of being with people experiencing distress, understanding and empathizing with the meaning people ascribe to their particular situations'
>
> *(Cutcliffe 1998 p 258)*

Cutcliffe (1998) is actually arguing for a major cultural shift in nursing, to utilise a qualitative research paradigm only. Such shifts could be recognised as near impossible in light of observations by Duffy (1985) and Playle (1995). Duffy (1985) suggests that the paradigm of the natural sciences has been enhanced as:

> 'truly scientific methodology'
>
> *(Duffy 1985 p 225)*

She contends that qualitative research has been regulated to secondary significance, even among Social Scientists.

Similarly Playle (1995), a whole decade later, critiques the textbook 'Nursing Research Principles and Methods' by Polit and Hungler (1995) as;

'establishing the positivistic bias and natural sciences as real research'

(Playle 1995 p 981)

He accuses nursing as having become infused with a 'positivistic ideology' (Playle 1995 p 981). This textbook (Polit and Hungler 1995) is rapidly becoming a seminal nursing research text, and is prescribed within countless pre and post registration nurse reading lists. It is relatively easy to defend Polit and Hungler however, with reference to their inclusion of qualitative research chapters, and sections clearly illustrating the limitations of the scientific method. The authors clearly detail how no single study can ever definitely prove or disprove our hunches, and the complexity and frequent inability of the method to capture human experience holistically or meaningfully, (Polit and Hungler, 1995 p 13-19).

Such critique however (Playle 1995, Duffy 1985, Cutcliffe 1998) cannot be ignored. Perhaps the disparity between the impacts of psychiatric nursing research on clinical practice observed within Cutcliffe (1998), relates to a continued hegemonic control of positivistic methodology over alternative research paradigms.

Critique of qualitative approaches certainly within the nursing literature is not as prevalent as critique of positivist, quantitative approaches. Carr-Hill (1997) in providing a commentary on the use of both approaches reminds us of the three most persistent criticisms of qualitative research;

- Researchers are subjective and data are biased
- Data collection is uncontrolled and cases have been selected non randomly
- Generalisation are not possible'

(Carr- Hill 1997 p 186)

Carr-Hill further relates the more sophisticated randomised control designs which have been developed, suggesting that a qualitative design is becoming a poor relation in the research family. Hill-Bailey (1997 p 18) goes further in suggesting that the 'trustworthiness of findings' in interpretive research approaches is a recurring theme in qualitative writing. The observations of Playle (1995) re quantitative methodology has been discussed earlier, however despite recognising a shift toward holistic individualistic approaches in nursing Playle (1995p980) questions how this philosophical standpoint manifests in practice. He discusses the reality of research being the focus of an academic elite and a small number of nurses. It is perhaps unsurprising then that the 'people focused', inductive approaches, and qualitative methodologies, purportedly favoured by nurses;

> 'are reserved for exploratory studies designed as the preliminary phase in a quantitative investigation'.
>
> *(Duffy 1985 p 225)*

Further, within the same article, he reminds researchers who are utilising qualitative approaches to exercise caution in the following areas;

> 'Biases and distortions from selective perceptions and interpretations/limitations on observable data or access to interviewees/'going native', the researcher over identifies with the participants/knowledge of the subjects/ researcher subject rapport/reactive effects of the study setting or other conditions which temper the behaviour or responses of the interviewee or those being observed'.
>
> *(Duffy 1985 p 229)*

Interestingly these areas of prescribed caution can be examined as key areas of criticism for the whole methodological approach. Because of its focus on meaning, and its emphasis on presenting the subjects reality, qualitative research can be criticised for its lack of focus on validity, and more significantly reliability. Holloway and Fulbrook (2001) remind us of common criticisms of qualitative research being associated with generalisation. The authors focus on external validity in particular, or the degree to which study results can be generalised

to samples other than that being studied. Similar to Duffy (1985) they also identify the importance of the status of their interviewer;

'Particularly if the interviewer is regarded as an expert'

(Holloway and Fulbrook 2001 p 548)

The concept of reactivity, or participants responding in what they perceive to be the 'right way' is a risk they suggest. They also comment on potential problems if, in nursing, the researcher knows all of the participants. There is a clear risk of such a previous knowledge or association influencing interviews.

3:4 An Alternative Paradigm?

Carr- Hill's (1997) commentary on a special edition of the Journal 'N.T. Research' focusing on a range of methodological approaches, questions the implied dichotomy between qualitative and quantitative research. His commentary questions the reality of serious debate between such methodologies asking;

'Are these, in fact, all false dichotomies'

(Carr-Hill 1997 p 185)

The rationale for such conclusions by Carr-Hill (ibid) can be found in the main body of the special edition of this Journal, where Schon (1983) [2] identifies how the practice of extreme rigour, technical problem solving and specialised scientific knowledge, has led to a knowledge hierarchy separating research from practice. Carr-Hill (1997) concludes that any dichotomy between quantitative and qualitative research is over played.

[2] Schon (1983) .....cited in Meyer and Batehup (1997)

Playle (1995) in discussing contradictions and conflicts in research concurs with Carr-Hill, and others, in identifying how;

> 'a polarisation of the notions of art and science have emerged'
>
> *(Playle 1995 p 983)*

This then leads the reader to complex debates about the specific heuristic required in nursing research. Of course we can be dismissive of the whole search process, or in seeking out advice on solving nursing, or indeed other, professional research problems, which would ultimately lead us to a position of stasis as opposed to progress.

Lakatos (1981) derides conventional approaches which allow for the 'building of any system of pigeonholes' which in turn organise facts and data into a coherent whole (ibid. p 110). A reconstruction of the debate is progressed by (Guba and Lincoln 1994 p 105) who infer that methodological questions are secondary to the choice of research paradigm, which they define as basic belief systems or worldview. This choice, they suggest would guide a researcher in both ontological and epistemological ways. In terms of supporting a mixed methodology this choice of paradigm is key, in their suggestion that:

> 'From our perspective, both qualitative and quantitative methods may be used appropriately with any research paradigm'
>
> *(Guba and Lincoln 1994 p 105)*

They go on to question why quantitative methodologies are privileged over the insights 'of creative and divergent thinkers' suggesting how qualitative inputs can readdress the balance'. The authors significantly critique accepted traditions of positivism by illustrating how philosophical shifts have led to a theory of 'post-positivism'. They also suggest that replicated findings are probably true, but because of Popperian philosophical influence are subject to falsification. They also further indicate how the increased use of qualitative techniques, complementing the simultaneous use of quantitative approaches, will reintroduce 'discovery'

as an element in inquiry and solicit the emic viewpoint, in contributing more meaning to research (Guba and Lincoln 1994 p 110). This Process requires a shift from a purely experimental manipulative method to a modified heuristic, or a 'transformation of the existing structure' (Guba and Lincoln 1994 p 114). Holloway and Fulbrook (2001) clearly recognise that many nurses and midwives are using both qualitative and quantitative methods in a single study, but go on to warn of the danger of different philosophical approaches. Guba and Lincoln (1994) however reassure the researcher that it is the paradigm choice, or worldview, which is more important. Hill-Bailey (1997 ps. 19, 20) concurs, and suggests that such an enlightened approach is empowering and emancipating the nurse from 'rigid methodological protocols now allows for the possibility of the recombination of the quantitative and qualitative paradigms'. She uses the terms 'post-positivism', 'critical theory' and 'constructionalism' to reflect both the ontological and epistemological shifts and developmental changes in recent years. She suggests that post modern researchers readily 'mix' the quantitative experimental model, and natural inquiry qualitative perspectives in their design, knowledge existing in both areas with the resultant need for a mixed methodology.

Polit and Hungler have defined the concept of triangulation as;

> 'The use of multiple methods or perspectives to collect and interpret data about some phenomenon to converge an accurate representation of reality'
>
> *(Polit and Hungler 1995 p 655)*

Certainly a move toward the use of a variety of data sources, or a mixed methodology would be an example of the process of triangulation. Both Playle (1995) and Duffy (1985 p. 229) recognised the importance of multi faceted data collection methods. He also suggests that such an approach 'minimises distortion' and provides assurance that the data is representative of the phenomenon being studied.

Playle (1995), despite misgivings that such an approach could be seen as giving the scientific method more credibility, writes that;

> 'if triangulation is utilized in order to gain different perspectives and alternative understandings then it may have something to offer'
>
> *(Playle 1995 p 984)*

Therefore it is apparent that the use of a reflective process, examining previous experience and alternative learning modes have progressed this researcher through a review and critique of a range of methodological approaches. The choice of a mixed methodology is perhaps typical of a divergent, imaginative approach, neither rejecting nor totally accepting of either heuristic.

3:5 The Use of Self-Report Data, and Questionnaire Development

The use of self-report data, usually in the form of a questionnaire is commonly used in nursing research and related health and social research (see Parahoo 1997 p 246). The frequent use of such self-report methods is discussed at length in two of the most widely used nursing research textbooks, (see Polit and Hungler 1995, Parahoo 1997). This research study is also reliant upon questionnaire or self-report data in two areas, albeit different in approach, regarding the rating of severity of maltreatment, amongst nursing staff, and in a separate questionnaire related to clinicians opinions and knowledge concerning concepts of abuse, mental illness and violence. As a consequence, so as to underpin my approach to devising these self-report instruments I undertook a review of the aforementioned literature. This review was largely based on my understanding of the need to devise a relatively loosely structured method of gathering data from both the nurse sample and the range of clinicians in the related study within this research.

Certainly, within the examination of the nurse respondents, and their determination of severity of maltreatment suffered by an inpatient group within a medium secure hospital, the use of secondary case file information was vital in this area of study. Parahoo (1997 p 247) indicates how such case file information is not primarily designed for the collection of research data,

however for the purposes of this research such files provided the necessary information, both demographic and clinical. In attempting to share a common vocabulary, researcher to researched a self-report method, which may be semi or unstructured is recommended (Polit and Hungler 1997 p 274).

Whilst the formulation of such self report instruments are clearly quantitative approaches, predetermined, constructed in advance and standardised, respondents being asked to choose from a list of responses generated by the researcher, they can be viewed as qualitative to an extent. Parahoo illustrates this latter point:

> 'in descriptive studies they (questionnaires) may not only provide data that facilitate understanding of the phenomena being investigated, but can also generate data from which concepts and hypotheses can be formulated. Thus they can contribute to the production of knowledge inductively'
>
> *(Parahoo 1997 p 247)*

The usefulness of such a design within this research enabled the combination of quantitative design and qualitative results to an extent. The examination of large amounts of information collected from many people over a wide geographical area is easily facilitated by the use of questionnaires, as is the collection of demographic factual data such as age, gender, occupation and qualifications (see Parahoo 1997 p 249). Similarly self-report methods facilitate the examination of attitudes, knowledge and beliefs of health professionals, and how they see their practice, as well as how they utilise research (ibid. p 250). Polit and Hungler (1995) outline what they consider to be some of the main strengths of using questionnaire as a design in research, among them:

- The ability to administer to groups
- Distribution in clinical settings is often inexpensive, efficient, and usually results in high yield
- A large geographically spread sample can be obtained
- Greater anonymity can enable candid response

- The lack of an interviewer creates a lack of interviewer bias

(see Polit and Hungler 1995 p 289)

Parahoo (1997) agrees with these observations, adding further that the structure and predetermined style of questionnaires provide a fair degree of reliability, closed questions being pre-coded and thus easy to analyse (ibid. p 263).

Within self administered questionnaires closed and open questions can be used, either allowing respondents to respond in their own way (open), or to offer a number of fixed alternative replies from which a respondent can choose (closed) (see Polit and Hungler 1995 p 276). Parahoo (1997) writes of a range of types of questions used in closed response questionnaires, dichotomous or two-way questions (or a choice between 2 responses) or multiple choice questions, a format in which a list of responses, normally in statement form, are provided from which the respondent chooses the most applicable to themselves (see Parahoo 1997 p 254). The author goes on to illustrate how closed questioning often yields data which allows for comparison between respondents, the responses usually being pre-coded, enabling quick and easy analysis, and in the same format (ibid. p 254). Polit and Hungler (1995) similarly relate how they consider closed ended items more efficient, and add that respondents are normally able to complete more closed than open questions in a given amount of time, subjects being less willing to compose a written response (ibid. p 276). Open-ended questions do allow respondents to engage and participate in the research however, providing a broader perspective on the topic, thus creating a feeling of more freedom in their scope to rationalise an answer, more than a fixed set of alternatives allows (see Polit and Hungler 1995 p 276, Parahoo 1997 ps. 254, 253).

Rating scales are also used in the design of questionnaires. In the systematic construction of the questionnaire the researcher will have selected a series of questions, which are believed to 'reflect attributes of the concept, or aspects, of such an issue to be studied' (Parahoo 1997 p 258). Rating questions, according to Polit and Hungler (1995) require respondents to judge something along an ordered dimension, are usually bipolar in nature, end points specifying an

opposite extreme of a continuum, i.e. strongly agree to strongly disagree, or less severe to life threatening (ibid. p 277). The authors further illustrate the use of Likert scales in this respect, where declarative items express a viewpoint on a topic, agreeing or disagreeing for example (ibid. p 281). This type of scale is best developed through the generation of 10 to 15 statements, stating different positions, using equal numbers of positively and negatively worded statements. Polit and Hungler (1995) further advise that in Likert scale generation neutral, or extreme, statements should be avoided, thus reducing the chances of large numbers of respondents either agreeing or disagreeing with the statement (ibid. p 281).

There are a number of disadvantages however in the use of questionnaire or self-report data within the research design. Parahoo (1997 ps. 275, 276) illustrate how some questionnaires can be formulated on the basis of a researchers own experience, as opposed to formulation based on the literature or an evidence base. The lack of reference to an evidence base, can clearly affect the content validity of a document, or the degree to which questions or items in a questionnaire adequately represent the phenomenon being studied (ibid. p 270). Examining criterion related validity can also enhance the validity of a questionnaire, when data are collected on the same phenomenon by other methods, such as another questionnaire or clinical observations (ibid. p 271). Polit and Hungler (1995) advise caution in ensuring an attractive physical appearance of questionnaire, (the layout, colour, and quality of paper) in affecting the response rates (the authors relate a response rate of greater than 60% as useful for most purposes). The authors (ibid.) also warn against the possibility of missing information, taking care over the order of questions and an awareness of response bias and extreme responses (ibid. ps. 289-290). The last two points are discussed as potentially serious disadvantages to using questionnaire within research design. Regarding response bias, the authors (ibid. p 290) highlight a pervasive problem, whereby a respondent wishes to present a favourable image of him or herself, a respondent would thus give answers which are congruent with social mores, as opposed to their true opinion. The authors (ibid. p 291) go on to discuss how confounding extreme responses can be, particularly associated with composite scales i.e. strongly agree to strongly disagree. 'Response Set' factors are referred to, where consistent endorsements of strongly agree, or its opposite extreme, or a neutral ground is actually a distorting influence rather than true opinion (ibid. p 291).

Parahoo concurs with these cautious observations regarding the use of questionnaires in research design particularly in terms of response bias:

> 'prestige bias, social desirability, ego or practical ethical standards are all different names for the same phenomenon'
>
> *(Parahoo 1997 p 266)*

Parahoo (1997) further relates how self administered questionnaires provide opportunities for respondents to confer with others or consult a range of other sources, and of how assessing the knowledge of health professionals can be perceived as a threat. The author (ibid. p 267) relates how respondents often give opinions, when asked, even if they have little or no knowledge on a subject, or when faced with multiple choice or checklist questions guess the answer, as opposed to providing an informed response.

The authors discussed within this brief review of questionnaires within research design, Polit and Hungler (1995) and Parahoo (1997) tend to err on the benefits of using self-report data, particularly in nursing. They warn however of not considering the semi structured approach as beyond the normal bounds of research design considerations. For example Parahoo (1997 p 277) reminds the researcher of the need for ethical approval for the use of self-administered questionnaires, and of how many do not believe such approval to be necessary. The author relates how the most innocuous questionnaire can open old wounds, with no one available to offer appropriate support.

The authors tend to conclude that such data can be very useful, especially if certain rules are considered important to the development of the questionnaire, these can be summarised as follows:

- Be clear in layout, instruction and wording of questions
- Enable respondents to provide information if required
- Attempt to create a document which minimises response bias

- Ensure that the process, researcher to researched has incorporated qualities of sensitivity, courtesy and consideration, particularly regarding sensitive information.

3:6 Cohen's Kappa Statistical Test and Health Care Research

Nurses and researchers have frequently grappled with the problem of translating theoretical models of mental health problems such as suicidal ideation, post traumatic stress disorder or the after effects of childhood abuse into phenomena which can be reliably detected in their clients. The use of the Cohen's Kappa statistic within this research has been instructive in this regard as it has been widely used as a measure of inter-rater reliability. A survey of its use in the mental health field will illustrate some of the problems that researchers face in achieving consistency in practitioners' judgments of clinically significant phenomena.

The research question related to consistency amongst nurses pointed toward statistical tests designed to measure agreement. Everitt (1992) writes of two observers separately classifying a sample of subjects using the same categorical scale, as in this study when nurses have been asked to rate severity of maltreatment utilising a scaled severity of maltreatment classification (see Appendix Five). Everitt (ibid. p 174) illustrates further the intuitively appealing index of agreement, which requires reviewing the proportion of agreements on the same category by two observers, a simple and easily understood determination of agreement. However such a method ignores the agreement between observers, which might have been due to chance. Everitt writes of the chance corrected measure of agreement generally known as the Kappa coefficient after Cohen (1960). Everitt cites Landis and Koch (1977), who have provided what are arbitrary, but useful benchmarks or convention for evaluating the observed values of the Kappa coefficient (K) (see Everitt 1992 p 149).

These benchmarks are given in the Everitt (ibid.) text as follows:

Table 5: Benchmark for evaluating observed values of Kappa Coefficient

K	Strength of agreement
0.00	Poor
0.00 – 0.20	Slight
0.21 – 0.04	Fair
0.41 – 0.60	Moderate
0.61 – 0.8.	Substantial
0.81 – 1.00	Almost perfect

(from Everitt 1992 p 149)

The Kappa statistic is therefore used to determine a level of agreement between two observers. In reviewing the nursing research literature it would appear that the use of the Cohen's Kappa (K) statistic is relatively limited. Further to the paucity of specific nursing research utilising this statistical method, there is scant literature regarding definite rules of interpreting Kappa values, however when used to determine inter-rater agreement of opinions about particular items then good agreement has been reported to equate to value recorded of 0.6 and above (see Everitt 1992).

Within a brief review of the nursing, and health care literature, this researcher looked to the conventional use of values, particularly in work involving nurses. As a consequence the work of Barer (2002 URL) proved useful. Whilst not a mental health care study this work bore relevance to my own work, utilising a value convention, which proved useful within the nurse respondents rating of severity of maltreatment during analysis of this research. Barer's work (ibid.) was a study involving, four nurses and other health care professionals. These nurses, having attended a course related to clinical assessment of swallowing, were asked to assess stroke patient's ability to swallow using a standardised

swallowing assessment. This assessment process related to nurses and other health care professionals making clinical decisions concerning a patients ability to hold their heads, finish a drink, and generally to rate a patient as safe, possibly unsafe, or definitely unsafe. The rating groups were divided according to the level of training they had received. Cohen's Kappa (K) was utilised to determine agreement because of its relevance to analysis of categorical variables.

The value convention ascribed to the agreement values was as follows:

> ' K = 0 indicates agreement no better or worse than chance
> K < 0.2 indicates poor agreement
> K 0.2 – 0.6 indicates fair to moderate agreement
> K > 0.6 indicates good agreement
> K = 1 indicates perfect agreement'

(Barer 2002 URL)

Barer's research found agreement overall to be good to fair, concluding that reliable assessment could be made after raters had completed a short course linked to standardised assessment of swallowing. The statistical test used for categorical variables was therefore able to indicate how much better, or worse, inter-observer agreement was than that expected by chance.

Another British study which has utilised Kappa statistics is a mental health study, but one which is also pertinent to a wide range of health care settings. Lucas et al (1997) examined deficiencies in communication, which were revealed in post incident inquiries. The focus of this study was linked to the parts of a community care plan, which were found to be difficult to communicate, between community mental health teams (CMHT's) and General Practitioners (GPs). As a consequence the research chose to compare CMHT care plans with GP care plans following discharge from hospital of a sample of patients. Kappa (K) was utilised in the determination of agreement within the two sets of care plans. Lower agreement

was revealed on items related to need, as opposed to items of fact, the example given being the need for a community psychiatric nurse. Similarly lower agreement was found when items required a named individual (i.e. a CPN), as opposed to when there was a binary choice, or a number of individuals to choose from for carrying out an action, or completing a task. There is a wide range of literature utilising Cohen's Kappa statistic as a form of analytical method, where nurses are involved. Isohanni et al (1996), in an American study developed a screening instrument (based on DSM III-R) to differentiate aged persons with or without a DSM III-R mental disorder. The use of this instrument was examined within six generic institutions. Nurses were asked to independently rate the mental status of residents of these institutions. The research found that the instrument was useful in differentiating mental disorder from DSM III-R mental disorder. The use of Kappa (K) in this instance revealed nursing staff agreement as 0.71. However the research found that only half of cases were diagnosed correctly. In employing a more specific diagnostic instrument, again developed from DSM III-R, the Kappa (K) agreement was calculated as 0.59. The authors concluded that whilst the instruments developed were useful, accurate diagnosis requires a good deal of psychiatric knowledge.

Another American study (Howard et al 1999) undertook a mental health survey of Filipino ethnic groups, six years after they had been displaced following a volcanic eruption. The study found that posttraumatic stress disorder and depression were the most frequent diagnoses. In conducting diagnostic test – retest interviewer agreement the researchers found, in using Cohen's Kappa (K), that agreement for both alcohol use and mood disorder ($K = 0.65$ and $K = 0.53$ respectively) was good. However the agreement was reduced for agreement on diagnoses of anxiety disorder ($K = 0.15$), and posttraumatic stress disorder ($K = 0.18$).

Clearly the use of Kappa in examining the reliability of new scales or instruments of assessment can be seen in the work of Isohanni et al (1996) previously cited. Further work in this area is illustrative of how useful Cohen's Kappa statistical analysis can be, and further how nurses are routinely involved in such work. Two studies, which illustrate this, are both studies, which involve the development/adaptation of scales of assessment in Spain and America respectively. Gournemann et al (1999) in a Spanish study, assessed agreement in

classification of impaired cognitive functioning in a sample of people aged 65 years and older. The short-portable mental status questionnaire (SPMSQ) was scrutinized by the research team to examine the effect of literacy status within items, further proposing items which were less biased by education. Thus different items were excluded from the scale. Cohen's Kappa was then used to measure agreement between the reduced and the whole scale, in the identification of those with cognitive impairment. When one, or more, items were excluded from the scale Kappa values were between 0.80 and 0.95. The research was thus able to determine that a shorter version of the scale was as reliable as the whole, ten item, version. The development of a new scale of assessment as opposed to the adaptation of an existing scale was addressed in the research of Horowitz et al (2001), an American study focusing on the screening of suicide amongst adolescents in an emergency department. This is a burgeoning area of development currently within the United Kingdom, often referred to as liaison psychiatry. The work (ibid.) recognised the lack of screening procedures in emergency departments, and the corresponding lack of specialised training in this area. Similarly the researchers found a lack of use of any screening tools or brief instruments to assess suicidal ideation or risk in such settings. The research therefore embarked upon the development of a screening tool to assess suicide risk in children and adolescents, examining those who are imminently at risk. Fourteen screening questions were identified examining risk of suicide (RSQ). These questions were derived from the literature and from interviews with mental health professionals. A Suicide Ideation Questionnaire (SIQ) was a further criterion standard developed to validate the RSQ. The SIQ is a thirty-item questionnaire assessing frequency of suicidal thoughts on a seven-point scale, 'almost every day' to 'never'. A triage nurse administered the RSQ, and a psychologist (blind to the results of the RSQ) administered the SIQ. The research, amongst other things, examined agreement between individual screening questions, and suicidality, as assessed by the SIQ. The research, in doing this, utilised the chance corrected Cohen's Kappa statistic, finding agreement to be fair to poor between screening items and suicidal ideation (determined by the scale), Kappa ranging from 0.54 to 0.02.

This brief overview of a range of international work has indicated the usefulness of the Cohen's Kappa statistic in health care research generally. Nurses are frequently involved in

such research, but the use of the statistical method cannot be said to be widespread in nursing circles as yet. However, as illustrated earlier in this section, the use of self-administered questionnaires is a widespread research method in nursing, and there is certainly scope for developing the use of Kappa analysis in conjunction with this popular method of data generation.

3.7 Methodological Process

The study comprised three broad areas of address, as follows:

1. Patient data collection within three medium secure units (MSU's) (Results I)

2. The distribution and analysis of a self administered rating scale amongst a number of nurses in all three MSU's (see Appendix Five, Results II)

3. The distribution and analysis of a self administered questionnaire to a range of clinicians in the three MSU's (see Appendix Six, Results III)

The three areas of focus were to incorporate the range of aims and objectives of the study (see Chapter One) utilising a number of methods of analysis, both quantitative and qualitative in nature. This mixed method approach incorporated a non-experimental design, which involved devising two self administered questionnaires (see Results II and Results III in this Chapter), as well as a sampling plan which focused on three MSU's each covering a wide geographical area of England and Wales. The measurements were both quantitative and qualitative, data analysis incorporating the Cohen's Kappa statistical test (see Chapter 3 Section 3:6), Chi Square tests of association, analysis of variance, joint probabilities determination, homogeneity analysis, the use of rating scales and themed content analysis. The combination of aims and objectives (see Chapter One) were, within the methodological approach to this study, largely governed by the constraints of access to medium secure hospital settings, specifically in terms of the type of data and data collection, the boundaries of quantitative and qualitative design, and the relevant literature, in its identification of areas of concern in forensic practice and forensic mental health nursing. The issue of ethical approval was never

in question because of the nature of this particular study. The data held in case files in medium secure hospital environments is sensitive in almost every respect. Principles of respect, of both patients and staff, had to be considered, as well as principles of beneficence. The range of methods, and methodological issues associated with this study entails a discussion of these issues and the subsequent methodological process, consequently the remaining sections of this chapter will provide an overview of each, in turn, related to the three broad areas of the study, as well as ethical approval obtained.

3:7.1 Ethical Approval: Methodological Issues

This study was one, which involved the following:

- Entry into a medium secure psychiatric hospital
- Access of clinical case files of all patients resident within such settings
- Permission to document, and code, demographic data, and data concerning abuse suffered by patients in childhood and adolescence
- Subsequent distribution of two questionnaires to nursing staff and other clinical staff working within the MSU's related to their rating of the recorded abuse, and their knowledge concerning aspects of associated forensic clinical practice

Clearly the sensitive nature of such work had to be considered particularly in terms of examining potential benefits and costs of the research to participants. In anticipating that the data collection and analysis would contribute new developmental knowledge to the field of forensic practice, and in how such research would contribute to the ongoing evolution of forensic mental health nursing as a specialty (see Peternelj-Taylor 2000 p 210), I began to view the potential benefits of the research as outweighing risks. However the risks were great, insofar as there were many issues concerned with the type of environment and patient group being used as the basis of the research.

Some of these issues revolved around the following:

- Confidentiality and ensuring anonymity
- Access to clinical notes
- The research taking place in a medico-legal environment
- The collection of data
- The use of a research contact in the three units
- Staff group sensitivity in rating severity of maltreatment

I was aware that any ethical approval board would be giving as much consideration to these issues as I would. Consequently within the formulation of my research submission to ethical boards, linked to all areas to be studied, it was important to ensure that they were addressed. There was also a need to devise a proforma associated with the data I intended to collect, along with assurances of confidentiality and anonymity (see Appendix Seven). The potential costs as opposed to the benefits would clearly have been linked to such issues, particularly that of maintaining anonymity regarding patient information used within the research. For instance the psychological and emotional distress resulting from the disclosure of information related to maltreatment suffered in childhood would be considerable. It is perhaps for this reason that this area remains relatively under researched to any great extent, other than the easily measurable demographic information concerning this patient group (see Chapter Two). The patients, whose case file information formed the basis of the whole study, could therefore be considered as vulnerable subjects, as defined by Polit and Hungler (1995 p 128). The authors (ibid.) suggest that mentally or emotionally disabled people have a disability making it impossible for them to weigh the risks and benefits of participation, and thus make an informed decision. In such cases, the authors (ibid.) recommend that the researcher obtain the written consent of each person's legal guardian. Similarly staff employed within institutions, such as hospitals sometimes face pressure to participate in such research, or indeed can be at risk of their employers knowing their opinions about certain aspects of practice. Such ethical considerations had to be considered, to minimise the risk to subjects (both patients and hospital staff) and ensure a successful ethical approval application.

3:7.2 Ethical Approval: Methodological Process

Formal application was made to the three overarching Mental Health Trusts regarding ethical approval to conduct the research. The following is illustrative of the protocol adopted regarding ethical approval:

- Completion of formal ethical approval documentation
- Include within the documentation information pertaining to:
    a. Academic supervision
    b. Clinical supervision
    c. Aims of research
    d. Supporting literature
    e. Appropriate experience
    f. Information concerning the design of instruments to be used
    g. The subjects of the research, and any discomfort or inconvenience they may experience
    h. How information/data will be collected/stored
    i. How confidentiality/anonymity will be maintained
    j. The overall benefits to patient care of the research
    k. How issues of consent are to be addressed
- Presentation to ethical approval board (if deemed necessary)

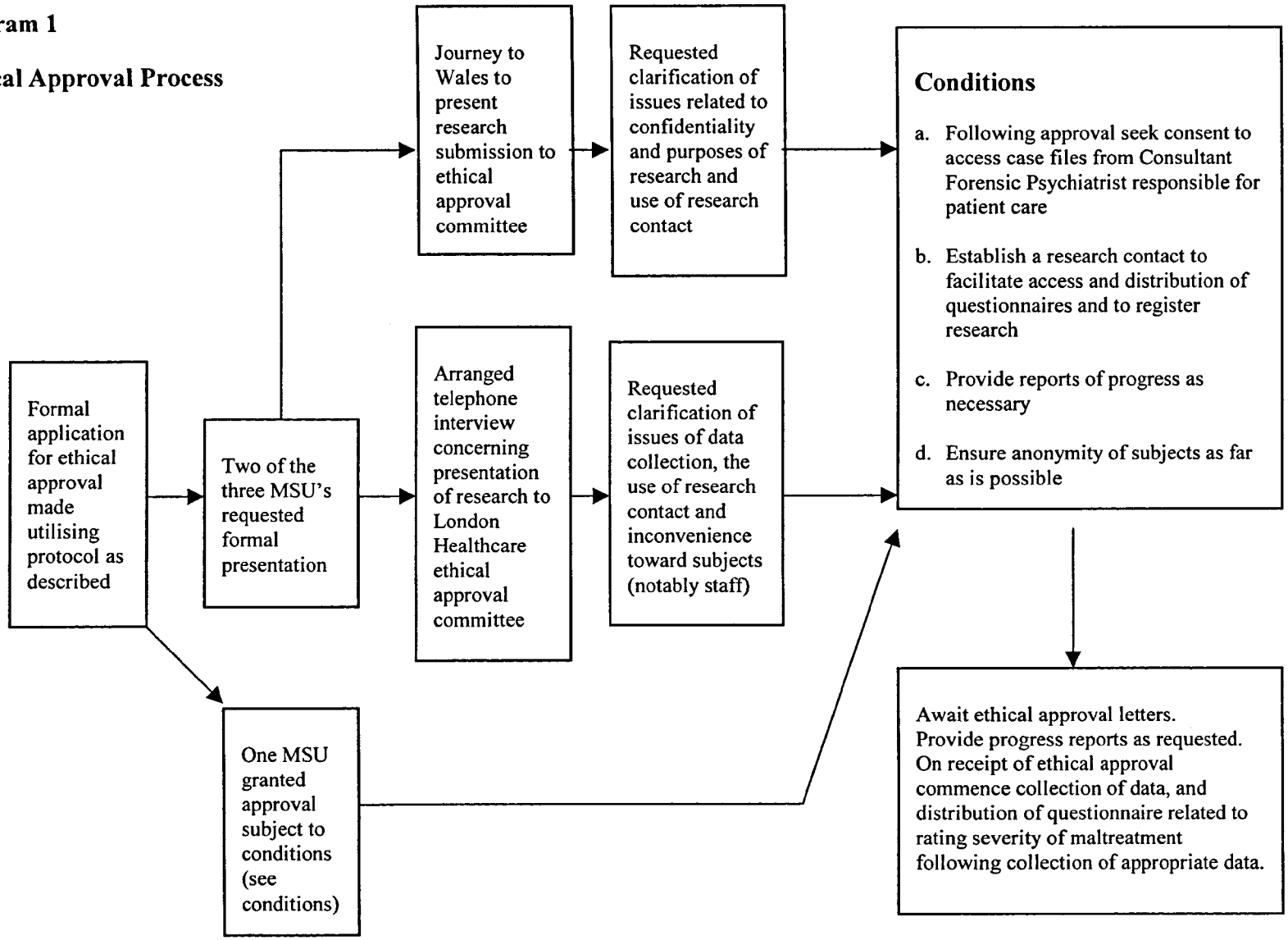
Diagram 1 illustrates the actual ethical approval process as it occurred in this study.

As can be seen in diagram 1 the concerns, and subsequent conditions set by the local ethical research committees were very similar. As expected their concerns related primarily to the ways in which I would maintain confidentiality, and limit inconvenience to both staff and patients. Because of the nature of the environment the establishment of a research contact was felt to be vital, so as to enable access and escorting throughout each secure hospital setting. The committees were particularly interested in my own clinical experience in such

environments, and my assurances of discretion and consideration during the process of data collection in what can be a very sensitive environment. Many patients within such settings are considered to be high profile, in terms of their public notoriety, and the often sensitive nature of index offences, which may have been committed, and many cases are actually sub judicae or awaiting trial. Because of such factors my methods of anonymising data was considered to be important in each of the boards' approval process. As indicated earlier, all of these areas had been considered prior to submission, and ethical approval was granted by each of the three committees accordingly (see Appendix Eight).

Diagram 1

Ethical Approval Process



3:8.1 Results I: Patient Data: Methodological Issues

Once ethical approval had been secured the collection of data was able to commence. Because of the nature of secure services the ethical committees recommendation concerning the use of a research link person proved extremely useful. In order to adhere to conditions set by each committee I communicated with the lead Consultant Forensic Psychiatrist in each of the three medium secure units, in order to secure permission to access clinical case notes. I also made contact with the Director of Nursing services in each unit to inform them of the ethical approval committee's decision, and to establish a link to further advise on a research contact. The Consultant Forensic Psychiatrists each took a copy of the research submission to their Consultant groups, and as a consequence agreed to my accessing clinical case notes in each unit.

The design of medium secure units is such that access is limited, and visiting staff are required to be escorted to wards within such units. Data collection was scheduled to take place in ward areas, usually in quiet rooms, and to be moved from ward to ward in each unit was sometimes difficult and time consuming. The collection of data from case notes was reliant on the case notes being freely available, and this too proved time consuming in that returns to the same ward were necessary in all three units. Thus collection of data in each of the units took a number of days. Another methodological issue related to the environment in which data collection took place, related to current clinical case notes usually having to remain in the ward area. The study required access to both current, and past volumes of clinical case notes to secure the necessary information. Medium secure unit wards can be volatile areas, and whilst I collected data from clinical case notes in a way, which was both discreet and courteous, the presence of an unknown individual in clinical areas was always a potential risk. This is clearly an area of consideration in data collection in such environments.

The population of patients within MSU's in England and Wales in the year 2000 was 1341 (DoH 2000/2001 p 2) (see Chapter Two). In identifying a population for this study, in-patients, as opposed to community patients were chosen, to enable ease of access to current case files. The accessible population however can be different to the population being

addressed within research (as identified by Polit and Hungler 1995 p 230), and was much smaller than this. The number of patients accessible to this researcher, as a pool of subjects, constituted 117 patients, or 8.7% of the English and Welsh MSU population. Thus the study population constituted the entire in-patient group of two of the MSU's under study, and approximately 50% of the third MSU (n=117). Within some of the constraints of this research, including time and travel, and the process of ethical approval, this 'target population' (in-patients of three MSU's) albeit more modest, was a more accessible population. The 'target population' has been defined as the aggregate of cases about which the researcher would like to make generalisations (see Polit and Hungler 1995 p 230). In order to secure a degree of representativeness the study considered the selection of the MSU's carefully. Whilst cognisant of the Department of Health survey (DoH 2000/2001) of patient characteristics in MSU's (see Chapter Two) this study endeavoured to select MSU's on the basis of broadly representative populations resident within them. As opposed to targeting all inner city London MSU's for instance, a rural Welsh MSU, an inner city London MSU, and a unit in a large town in the North East of England formed the focus of the study. Thus sampling bias could potentially be reduced, the systematic over representation or under representation of, for example, African Caribbean patients (see Chapter Two) would be eliminated to a large extent.

There was a further recognition of the need to identify sub populations or strata within the study. The initial focus of the study had to determine the prevalence of both violent offending and maltreatment suffered in childhood and adolescence from information within the clinical notes. Ethical approval, (as discussed earlier in this section) required that the research protocol clearly indicate what data was to be recorded from the clinical notes. A simple proforma has been developed which mirrored the patient information sheet in clinical notes recording name, date of birth, gender, legal and mental status, ethnicity and diagnosis, which were all felt to be important to a process of profiling the patient group (see Appendix Seven).

The patient data proforma (see Appendix Seven) also enabled documentation of the index offence details, so to determine whether the offence has been violent or not. Further documentation of a previous history (during childhood/adolescence) of maltreatment was also

recorded from the case files. It was clear that certain operational definitions were required for identifying what constituted maltreatment or abuse in childhood/adolescence as well as what could be defined as a violent offence. This study reviewed concepts of violence and mental disorder thoroughly within Chapter Two, and recognised the scope for difference in interpretation in defining a crime of violence, and the range of definitions of maltreatment. Consequently the choice of operational definitions in this study looked to clear definition, so as to more easily develop strata within the data. The definitions chosen were as follows:

For violent index offence:

- The definition provided by Archer and Browne (1989 pp 10-11) 'the exercise of physical force, so as to injure or damage persons or property; otherwise to treat or use persons property in a way that causes bodily injury and forcibly interferes with personal freedom'

- This definition (Archer and Browne 1989) combined with the use of Browne and Herbert's (1997) Two way classification of violence (see Chapter Two; Table 2) incorporating both active abuse examples as well as passive neglect examples, was felt to be sufficiently broad enough to be used as an operational definition

The operational definition utilised in determining childhood and adolescent abuse within clinical notes was important in reducing researcher bias. The Department of Health (UK) guidelines are recognised as being subject to less variation than many research definitions in this area (see Corby 1993 p 43, Chapter Two). As a consequence the definitions of the Department of Health (1999c) (see Chapter Two p 46) were used to determine abuse/maltreatment as suffered by the population (n=117). The information recorded on the proforma document (see Appendix Seven) thus enabled a profile to be formulated, which contextualised demographic data with abuse/maltreatment suffered, and a violent index offence. This profile enabled data collection of areas not generally available in the public domain, which in turn enabled the presentation of descriptive data and quantitative analysis.

3:8.2 Results I: Methodological Process

The data collection involved an advance process of coding with regard to the demographic data, enabling easier analysis with the statistics package used (SPSS 10). Certain variables were assigned a dichotomous response i.e. index offence = violent, yes or no, and multiple response was used for variables such as marital status i.e. married, single, divorced, widowed. Each of these variables were coded in number form. The data concerning abuse/maltreatment suffered in childhood/adolescence was, when found, anonymised to gender and place (see Appendix Nine for anonymised abuse cases. N.B. These are the randomly selected cases n=24). This anonymising process served a dual purpose, in both ensuring greater confidentiality in the recording of such sensitive information, and providing a reduced chance of bias amongst nurse respondents in rating maltreatment severity at a later stage of the study. ICD-10 coding (World Health Organisation 1992) was utilised for the diagnoses recorded in the clinical case notes.

Thus the collection of the demographic data enabled a range of descriptive observations regarding age, gender, diagnosis, legal status, mental status, ethnicity, index offence and abuse/maltreatment suffered on patient data set (n=117) (see Chapter Four, Results I). The generation of this categorical, or nominal data in relation to an overarching hypothesis of there being no association between the variables (Ho), or there being an association between variables classically pointed toward the use of a Chi-Square test of association. This test has been defined as:

> 'a non parametric test of statistical significance used to assess whether a relationship exists between two nominal level variables. Symbolised as χ^2 '
>
> *(Polit and Hungler 1995 p 637)*

These particular variables were of key interest on the profile of the patient group, to this research in terms of its focus of interest and aims and objectives (see Chapter One/Chapter Two). There are further descriptive data recorded in Results I, notably the mean and median age broken down through the range of recorded variables, i.e. gender, index offence,

diagnosis. The mean, as index of central tendency, and the median, as the average position in a distribution, were thought to be useful in respect of comparison to larger surveys of MSU's in England and Wales (see Chapter Two).

A joint probability determination or calculation of expectation of both abuse and index offence was calculated, as this particular probability was of interest to this study (see Chapter Two). Joint probability can be calculated to compare an expected value with an observed value, as when using Chi-Square analysis. However a Chi-Square test was not completed in this instance as one of the observed values was recorded as less than five (see Table 9). This calculation was specifically undertaken to outline percentile observations of joint probabilities occurring in the target population (n=117). In sampling from a population of all patients resident in MSU's, it was clear that figures for the proportions of in-patients that have been abused, and have committed a violent index offence were unknown. In being able to sample the population, (albeit only 117 patients) this study was able to reflect the sample into the population overall. This is therefore a probability determination of an expectation of being non-abused with a violent index offence, abused with a violent index offence, non-abused with a non-violent index offence, and abused with a non- violent index offence.

3:9.1 Results II: Maltreatment Questionnaire: Methodological Issues

The collection of patient data had enabled this study to extract from a target population a series of abuse case histories from those resident within the MSU's. The case history of each patient however was far from detailed. Much of the information concerning maltreatment suffered in childhood/adolescence was brief and difficult to find. The study had not proposed to clarify issues concerning maltreatment either with the patient concerned or with staff, and if no information was recorded concerning maltreatment then patients were placed in the non-abused sub sample. Thus one of the methodological issues related to the retrospective design of this part of the study concerned the reliance on existing data, probably not collected for research purposes, (see Parahoo 1997 p 161). This was obviously an issue within this methodological approach, unreported information concerning childhood maltreatment does not necessarily mean it did not happen. The anonymising of patient data related to abuse was

undertaken, as discussed earlier in this Chapter. The information documented from the clinical case notes (anonymised) can be found in Appendix Nine.

The focus of this study related to the rating of severity of maltreatment amongst nurse respondents. Consequently permission was sought to utilise an adaptation of a severity of maltreatment classification (see Chapter Two, Appendix Two) developed by Professor Kevin Browne of the University of Birmingham (see Browne and Herbert 1997). Permission was given and this classification was combined with a series of cases of abuse into a questionnaire format (see Appendix Five), incorporating a request to rate the information in the corresponding case, as per the classification. The ratings were determined as less severe, moderately severe, very severe and life threatening. There was an issue however, related to the ability of respondents to give consideration to multiple forms of maltreatment in the use of such a classification system, an issue which had been recognised by the author when developing the classification (see Browne and Herbert 1997, Chapter Two).

Even in selecting fifty percent of the abuse cases, the questionnaire proved to be quite long, requiring a good deal of time on the part of the respondent in completion. The design of such a self-report instrument lends itself well to nursing research (see earlier in this Chapter). The combination of a closed ended rating scale (responding to a rating request of less severe to life threatening), and the request for a rationale for this response enabled both a quantitative and qualitative analysis. The fact that a Likert Scale, asking for a self assessment of competence in making a judgement of severity, was to be included within this questionnaire afforded a degree of triangulation in the research, or the use of multiple methods or perspectives to interpret data about this phenomena (see Polit and Hungler 1995 p 655).

A further methodological issue was the geographical spread of the MSU's, North and South England and South Wales. The use of a research contact in each of the units enabled delivery and collection of questionnaires by the researcher, using the contact as a point of delivery. Explanation, and clarification of the aims of each section of the method could be undertaken with the research contact. This was invaluable in dealing with such a wide geographical spread of MSU's. This avoided putting sensitive information concerning abused patients

(despite the anonymising process) in the mail. Distribution over a wide area enabled a greater degree of anonymity and reduced interviewer or researcher bias also.

The study reflected upon the literature, in determining the demographic information to be recorded in the maltreatment questionnaire. In particular, the work by Storey and Dale (1999) examined staff demographics, which looked to areas such as job grades, job titles, age bands and years worked, as well as secure environment experience (see Storey and Dale 1999 p 147). This study was as equally interested in the profile of nurse respondents, correspondingly ensuring that the gender, age, year of qualification, length of experience, registration qualification and post registration qualification were instituted within the questionnaire.

The two main methods of analysis reflected the multi method approach to this study. The use of the Cohen's Kappa statistical test in health care settings has been discussed earlier in this Chapter. The advantage of using this method of analysis over another was primarily related to the focus of this aspect of the study. The examination of clinical decision making and consistency amongst nurse respondents and Nurse Consultants, against a Benchmark Nurse did not require a hypothesis test, but one which examined level of agreement, or inter-rater agreement of opinions about particular items. The literature related to the use of Kappa (see earlier in this work), whilst indicating that it is not widely used in nursing research circles, reflects its usefulness when utilised in study attempting to break new ground in assessment in mental health settings. Tests of significance against the data generated in Results II were therefore felt to be inappropriate, tests of inter and intra reliability, related to respondents with different levels of experience and qualifications, were however felt to be more appropriate. The methodological consideration was one related to not comparing like with like, hence the use of Kappa over statistical tests requiring specific hypothesis such as rank correlation. Significance tests would have been focused on the difference between respondents, as opposed to Kappa, which focuses on levels of agreement. The respondents, in providing a rationale enabled a themed qualitative analysis of different groups (nurses, Nurse Consultants) as well as an understanding of their use of the classification system. Thus the questionnaire design in its combination of demographic data, self-administered rating scales and rationale

for responses enabled this research to undertake a recording of qualitative, quantitative and descriptive data (for questionnaire see Appendix Five).

3:9.2 Results II: Maltreatment Questionnaire: Methodological Process

The process involved in developing the maltreatment questionnaire involved the following:

- Anonymising abuse histories
- Selection of every other case of abuse, as it naturally occurred during data collection (total number of cases used in the questionnaire = 24)(see Appendix Nine)
- Permission (telephone contact) sought, and given, from Professor K. Browne to use severity of maltreatment classification adaptation (see Appendix Two)
- The inclusion of a range of demographic information to be completed by nurse respondents
- The composition of a cover letter of explanation to respondents
- The inclusion of a Likert scale related to experience having prepared nurse respondents to make competent judgments of severity of maltreatment
- Reference to the evidence base regarding questionnaire design (please see earlier in Chapter Three)

(For maltreatment questionnaire please see Appendix Five)

The delivery of each set of fifteen questionnaires to the MSU's (a total of 50 including those sent to the Nurse Consultants and Benchmark Nurse) was carried out in person, as opposed to by post for reasons explained earlier in this Chapter. The research contact in each unit was asked to distribute the questionnaire to qualified nursing staff in the respective units. Assurances were provided by the research contact that this distribution would occur over the whole of the unit, as opposed to one ward area, thus minimising the chances of discussion of ratings amongst nursing staff. The research contact was the person responsible for the distribution and collection of questionnaires from the respondents, utilising the internal post system in each MSU. The research contact was further tasked with the responsibility of a

prompt after three weeks if questionnaires had not been returned. This researcher visited the MSU to collect returned questionnaires after this period had elapsed.

Completion of the questionnaire was also undertaken by this researcher (Benchmark Nurse) blind to the completed questionnaires of the nurse respondents, or Nurse Consultant respondents. Questionnaires were delivered to four Nurse Consultants working in secure environments for completion as above. Analysis was undertaken as follows:

- Chi-Square tests of association were undertaken on the nurse respondent sample (n=34) concerning variables outlined within Chapter One of this study (see Results II). Chi-Square tests did not satisfy criteria for minimum standards.

- The Cohen's Kappa statistical test analysing levels of agreement between the nurse respondents, and the Nurse Consultants against the benchmark Nurse was undertaken. The convention utilised by Barer (URL 2002) was employed in determining levels of agreement (see Chapter Three, Section 6). SPSS 10 statistical package was used in the analysis of this data.

- Key themes emerging from the nurse respondents' ratings of maltreatment utilising the severity of maltreatment classification were analysed, as were key themes from each of the case studies. Observations and themes evident in the Nurse Consultant respondents' rationale were also analysed, as well as those themes evident in both the Nurse Consultants and Benchmark Nurse responses. An overview of observations and themes concerning specific respondents were analysed as well as a review of missing data.

- Rounded means were calculated for the respondents self-rating of competency concerning ratings of severity of maltreatment suffered.

3:10.1 Results III: Knowledge Questionnaire: Methodological Issues

Another aspect of this research related to an examination of knowledge base and opinion concerning concepts of mental disorder, violence and abuse/maltreatment behaviours. As with the development of the questionnaire related to maltreatment rating (see Appendix Five), discussed earlier, this study recognised the advantages offered by such a data collection

method to this area. It was anticipated that such a design would enable further understanding of the phenomenon of abuse and its association with violence and/or mental disorder through the generation of data from which concepts and hypotheses could be formulated, in research which might be undertaken as a consequence of this study (see Parahoo 1997 p 247). Again, this study endeavoured to combine quantitative design and analysis as well as ensuring the inclusion of qualitative data and analysis, by enabling respondents to provide a rationale for their responses to a series of questions. In offering fixed, alternative replies to a number of declarative statements, comparison between groups could be made. It was anticipated that the use of closed ended questions would be more efficient, be easier to analyse, and enable respondents to complete more of the questions, than would be expected if long written responses were requested. Hence the actual design of the questionnaire (see Appendix Six) allowed one third of a side of A4 sheet in which to provide a rationale for each response. The number of statements, to be included in the questionnaire, was determined as fifteen, reflecting best practice in this area of research design (see Polit and Hungler 1995 p 281). A Likert scale was felt to be appropriate, to determine the staff members viewpoint concerning items within the questionnaire, a rating scale of strongly agree to strongly disagree being used in this instance.

One of the key methodological considerations however related to the choice of statements or information which was to be included in the knowledge questionnaire. There is often a danger in this area that researchers will develop a series of statements based upon their own experience, as opposed to formulation based on the literature or evidence base (see Parahoo 1997 ps. 275-276). This particular methodological issue relates closely to the content validity of the questionnaire, or the degree to which items adequately represent the phenomenon being studied. This study consequently gave great consideration to this issue, and as a result the justification and evidence base of statements included within the questionnaire can be found in Chapter Two.

The following are some examples of specific justification for inclusion of certain statements (for questionnaire see Appendix Six):

- *Statement 1*

  This statement is supported by various work discussed with Chapter Two, Corby (1993), Browne and Herbert (1997)

- *Statement 2*

  Supported to an extent (see Chapter Two), Spatz Widom (1989b), Blackburn (1995), Browne and Herbert (1997), Daveson (1982), Corby (1993), Newcombe and Locke (2001)

- *Statement 3*

  Weeks and Widom (1998) neither refuting nor supporting but advising caution in ascribing causality

- *Statement 4*

  The evidence base is varied both in support, and lack of support for this statement. Weeks and Widom (1998) advising caution in ascribing causality, but DoH (1999) referring to the ongoing impact of abuse. Owens and Straus (1975), Bandura (1973) and Herzberger (1983) write of the higher likelihood of violent behaviour in adulthood when violence is witnessed or experienced as a child

- *Statement 6*

  The DoH (1999) write of the concept of significant harm as it applies to either natural parents, or guardians of children, Browne (1993) writing of the NSPCC report of the same year finding that there are three children dying at the hands of their parents each week

- *Statement 8*

  Humphreys and Ramsey (1993), Peckham (1980), Creighton (1988), Browne and Herbert (1997) all discuss the importance of severity of maltreatment, as does the work of Downs and Miller (1998)

- *Statement 11*

  Weiler and Widom (1996) revealing higher PCL-R scores amongst adults who were victims of childhood abuse and neglect. Marshall and Barbaree (1989) write of exposure to maladaptive parenting styles and subsequent developmental problems, Mullen (1993) writes of increased rates of mental disorders amongst those with a history of sexual abuse

- *Statement 13*

  Ryan (1989) writing of how 54% of North American abusers in his study were blood relatives of victims. Browne and Herbert (1997) write of children learning to be violent in the family setting in which a violent parent is taken as the role model. Support for a cycle of violence can also be seen in the work of Walsh and Rosen (1988), Spatz Widom (1989a), Kratcoski (1982) and Weiler and Widom (1996).

In examining the attitudes, knowledge and beliefs of clinicians working in the MSU's this research endeavoured to review clinicians' knowledge of research and the evidence base related to the items included within the questionnaire. The self-administered data collection method was therefore one way to determine clinicians' knowledge of, and attitudes to, research, which may determine whether and how they utilise research in the future (see Parahoo 1997 p 250).

As with the severity of maltreatment questionnaire discussed earlier, this study wished to profile the respondents to the survey within the MSU's. To this end a series of questions were attached to the questionnaire related to professional group, years of service, gender and whether the respondent had worked with an abused individual, or been involved in a violent incident in the work pace during the previous year.

As in previous sections of this study the methodology wished to incorporate both quantitative and qualitative analysis, combining a themed content analysis of the rationale provided for each response, as well as measuring mean levels of agreement, and analysis of variance between professional groups. The use of homogeneity analysis (also known by the acronym Homals) was also a preferred method of analysis for the range of nominal variables identified in the Results III section of this study. The goal of Homals is to describe the relationships

between two or more nominal variables in multi dimensional space containing both variable categories and objects in those categories. The analysis places objects within the same category close to each other on a plot, where objects in different categories are correspondingly plotted far apart (see SPSS 10 tutorial information). Homogeneity analysis was therefore considered useful in graphically displaying information related to profession, gender and the variables of having worked with those who have been abused, and having been involved in a violent incident in the previous twelve months (see Graph Two, Chapter Four).

3.10.2 Results III: Knowledge Questionnaire: Methodological Process

The process involved in compiling and distributing the knowledge questionnaire was as follows:

- Development of the questionnaire based on the evidence base and literature (see section 3.5 in Chapter Three)
- The adoption of a Likert scale, strongly agree to strongly disagree, and the inclusion of a facility to provide a rationale
- Development of additional questions to further profile respondent group (see questionnaire, Appendix Six)
- Establish link with research contact for purposes of distribution to five professional groups within MSU's, nurses psychiatrists, occupational therapists, social workers and psychologists
- Post 30 copies of the questionnaire to each of the three MSU's
- Request that the research contact distribute questionnaires as evenly as possible throughout the professional groups previously described, within each MSU
- Allow three week period, before requesting prompt from research contact to professional groups within the MSU's regarding return of questionnaires
- Collate returned questionnaires
- Analyse data

The process of analysis of the questionnaire included the following:

- The recording of a series of descriptive observations concerning response rate, mean years of service, gender split of respondents, percentile observations regarding profession, and similar observations for sub groups who had worked with those who had been abused and previously involved in a violent incident

- An identification of mean level of agreement (rounded mean) across the range of professional groups surveyed

- Themed content analysis emerging from the rationale provided by respondents (n=34) for agreement or non-agreement to statement 1-15 (see Appendix Six). Themed analysis is undertaken to examine differences in professional groups, identify broad themes of focus, and a further identification of positive and negative observations regarding rationale provided by respondents (see Table 14)

- A one-way analysis of variance was undertaken for mean agreement levels by profession. This procedure was chosen because of its preferred use in; 'testing mean differences among three or more groups by comparing the variability within groups' (see Polit and Hungler 1995 p 635)

- Homogeneity analysis was undertaken on the variables recorded within the questionnaire (see Appendix Six) regarding profession, having worked with those who have been abused, involved in a violent incident and gender (see Graph 2). This categorical data analysis method was chosen to graphically display relationships between a range of nominal variables (see previous section in this Chapter)

Chapter Four: Results

4:0 Results 1: Patient Data set (n=117), descriptive observations and analyses

Table 6: Descriptive Observations on Patient Data Set (n = 117)

Descriptor		Observation (n = 117)	Non-Abused (n = 69)	Abused (n = 48)
Gender	Male	91 (77.8%)	62	29
	Female	26 (22.2%)	7	19
Diagnosis (ICD-10)	F10-19	1 (0.9%)	1	0
	F20-29	95 (81.2%)	55	40
	F30-39	6 (5.1%)	4	2
	F40-48	1 (0.9%)	1	0
	F60-69	6 (5.1%)	3	3
	F70-79	1 (0.9%)	1	0
	F99	5 (4.3%)	3	2
	Non-specific	2 (1.7%)	1	1
Legal Status	3	15 (12.8%)	10	5
	5(2)	1 (0.9%)	1	0
	37	11 (9.4%)	3	8
	37/41	70 (59.8%)	43	27
	47/49	10 (8.5%)	5	5
	48/49	6 (5.1%)	4	2
	Informal	1 (0.9%)	1	0
	48	1 (0.9%)	1	0
	38	2 (1.7%)	1	1
Marital Status	Single	91 (77.8%)	49	42
	Married	12 (10.3%)	9	3
	Divorced	7 (6%)	4	3
	Unknown	5 (4.3%)	5	0
	Widowed	2 (1.7%)	2	0
Ethnic Origin	Caucasian	82 (70.1%)	45	37
	African/ Caribbean	17 (14.5%)	11	6
	Asian	11 (9.4%)	7	4
	Other	7 (6%)	6	1
Index Offence	Violent	110 (94%)	63	47
	Non-violent	7 (6%)	6	1
Abuse/Neglect Suffered				
	Yes	48 (41%)		
	No	69 (59%)		

Table 7: Descriptive Observations on Ages within Patient Data Set (n = 117)

Descriptor	Mean Age	Median Age
Age	37.8	36
Gender		
Male	38.4	37
Female	35.85	32.5
Index Offence		
Violent	38.1	36
Non-violent	33.57	29
Abuse/Neglect suffered		
Yes	36.83	35
No	38.52	37
Diagnosis		
Schizophrenia	36.79	35
Mood	48.33	54
Personality Disorder	45.33	40
Unspecified	37.40	32
No specific	32	32

Please Refer to Appendix 12

Table 8: Chi –Square Analysis: Patient Data (n=117)

Variable tested	Significance	Hypothesis supported
Gender v Abuse/Neglect suffered	< 0.001	H_1

H_0 – No association between variables tested
H_1 - Is association between variables tested

A two-by-two table also supported the alternative hypothesis after application of Yate's Correction.

Tabulations were obtained for:

- Gender and index offence
- Legal status and abuse/neglect suffered
- Index offence and abuse/neglect suffered
- Marital status and abuse/neglect suffered
- Ethnic origin and abuse/neglect suffered
- Gender and marital status

(These did not conform to the criteria for a Chi-Square test) However this information did prove useful as part of a series of descriptive observations.

Please Refer to Appendix 11 and Appendix 13

Table 9: Joint Probabilities Abuse/Index Offence

	Violent index Offence (Pr)	Non Violent Index Offence (Pr)	Totals
Abused (Pr)	47 (0.402)	1 (0.009)	48
Non-abused	63 (0.538)	6 (0.051)	69
Totals	110	7	117

4:1 Results 11: Maltreatment Questionnaire, Descriptive observations and analyses

Maltreatment Questionnaire

Forty-five distributed (fifteen to each of the three units under study)

Table 10: Maltreatment Questionnaire: Response rate

Unit	Unit A	Unit B	Unit C
Questionnaires Distributed	15	15	15
Questionnaires returned	13	10	6
% Response	86.6	66.6	40

Questionnaires distributed to four Nurse Consultants (100% return)

Questionnaire distributed to one Benchmark Nurse (100% return)

Sample size n = 34 Overall response rate = 68%

Descriptive Observations.

The gender split for the sample was 15 males (44.1%) and 19 Females (55.9%).

The sample comprised 8 (23.5%) in the age range 21 up to 30 years; 14 (41.2%) in the age range 30 up to 40 years and 12 (35.3%) aged 40 years and over.

The sample comprised 9 (26.5%) in the experience range 0 up to 5 years; 6 (17.6%) in the experience range 5 up to 10 years and 19 (55.9%) experienced 10 years and over.

The sample comprised 1 (2.9%) for the EN qualification; 23 (67.6%) for the RMN qualification; 6 (17.6%) for the RMN Dip. qualification; 2 (5.9%) for the RMN Advanced Dip. qualification; and 2 (5.9%) for the RMN Degree qualification. NB. These all represented registration qualifications.

The sample comprised 8 (23.5%) for the Forensic qualification; 14 (41.2%) for the Non-Forensic qualification and 12 (35.3%) for no qualification. NB. These all represented post-registration qualifications.

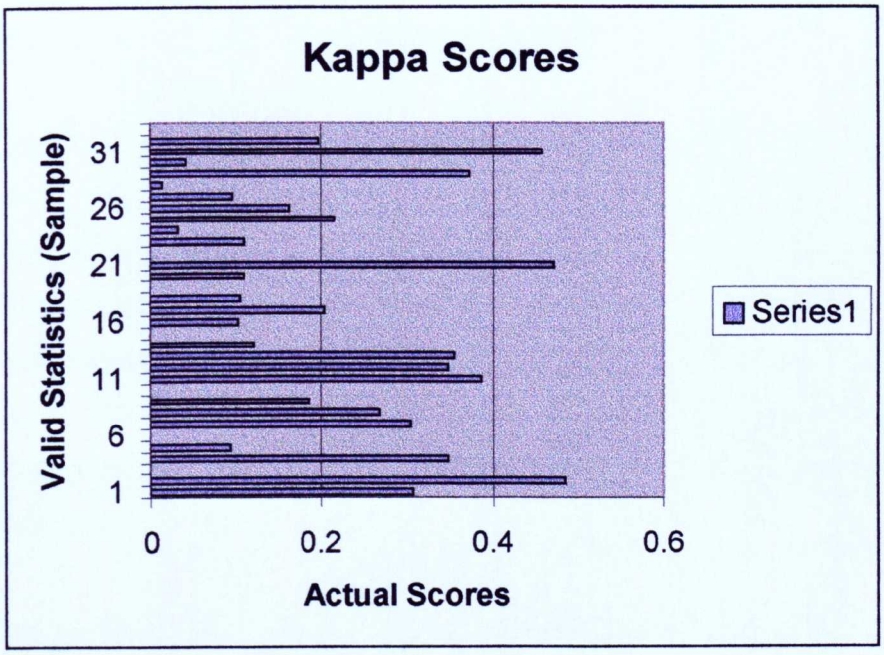
Chi-Square tests undertaken for this sample did not satisfy criteria for minimum observations.

Table 11: Kappa Statistics for Comparison of sample with Benchmark Nurse

Variables tested	Kappa Statistic	Agreement Comment
Variable 1 v Variable 34	0.306	Fair to Moderate Agreement
Variable 2 v Variable 34	0.486	Fair to Moderate Agreement
Variable 3 v Variable 34	Not Valid	
Variable 4 v Variable 34	0.348	Fair to Moderate Agreement
Variable 5 v Variable 34	0.094	Poor Agreement
Variable 6 v Variable 34	Not Valid	
Variable 7 v Variable 34	0.304	Fair to Moderate Agreement
Variable 8 v Variable 34	0.269	Fair to Moderate Agreement
Variable 9 v Variable 34	0.186	Poor Agreement
Variable 10 v Variable 34	Not Valid	
Variable 11 v Variable 34	0.386	Fair to Moderate Agreement
Variable 12 v Variable 34	0.347	Fair to Moderate Agreement
Variable 13 v Variable 34	0.356	Fair to Moderate Agreement
Variable 14 v Variable 34	0.122	Poor Agreement
Variable 15 v Variable 34	Not Valid	
Variable 16 v Variable 34	0.104	Poor Agreement
Variable 17 v Variable 34	0.204	Fair to Moderate Agreement
Variable 18 v Variable 34	0.105	Poor Agreement
Variable 19 v Variable 34	Not Valid	
Variable 20 v Variable 34	0.109	Poor Agreement
Variable 21 v Variable 34	0.471	Fair to Moderate Agreement
Variable 22 v Variable 34	Not Valid	
Variable 23 v Variable 34	0.111	Poor Agreement
Variable 24 v Variable 34	0.033	Poor Agreement
Variable 25 v Variable 34	0.215	Fair to Moderate Agreement
Variable 26 v Variable 34	0.162	Poor Agreement
Variable 27 v Variable 34	0.096	Poor Agreement
Variable 28 v Variable 34	0.013	Poor Agreement
Variable 29 v Variable 34	0.373	Fair to Moderate Agreement
Variable 30 v Variable 34	0.042	Poor Agreement
Variable 31 v Variable 34	0.459	Fair to Moderate Agreement
Variable 32 v Variable 34	0.198	Poor Agreement
Variable 33 v Variable 34	Not Valid	

Please Refer to Appendix 14

Graph One: Kappa Agreement Levels: Nurse Respondents (n=34)



Please Refer to Appendix 14

Key themes emerging from the Nurse ratings of causes of abuse utilising the severity of maltreatment classification

(for details of each case study please see Appendix Nine)

The following results section will describe the key themes emerging from the rationale provided by respondents (n=34), for their ratings of severity of maltreatment, suffered by the sample of cases (n=24) (please see Appendix Nine). The overall emergent themes evident in the rationale provided by the respondent group (n=34), will be discussed, as well as a range of observations from both the Nurse consultant group (n=4), and from the Benchmark Nurse (n=1). I will also provide some early discursive material related to the concerns and uncertainties evident within the rationale provided by nursing staff related to specific ratings provided.

Respondents one to four were Nurse Consultants, respondents five to thirty-three were Mental Health Nurses working in the three Medium Secure Units, the focus of this research. Respondent thirty-four was the Benchmark Nurse, the author of this research.

Respondent six, nineteen, twenty-one and twenty-two, provided no rationale to any of their ratings of severity of maltreatment for any of the case studies.

Key themes from each of the case studies

(NB case studies are referred to by the number allocated during random selection, not in sequential order)

Case 3

The respondents were almost equally split between ratings of moderately severe and very severe regarding case 3. One respondent thought the case warranted a rating of 'life threatening', another respondent thought the case 'less severe'. Respondents variously

identified evidence of emotional physical and sexual abuse in the case study, but a number indicated that they saw no evidence of neglect within the information provided rating case 3 as 'less severe'.

Some of the comments from the respondents were as follows:

> 'there is clearly the potential for long term psychological damage, there would be fear of mother, fear of men, people in power are abusers, there is evidence of frequent maltreatment, this person will likely become an abuser themselves'
>
> 'there are two reports of non-consensual sexual activity and my rating is therefore 'life threatening''

One respondent who rated the case as 'very severe' commented on his knowledge of a similar case where there had been long-term psychological damage.

Case 5

The majority of respondents (19 out of 34) rated case 5 as 'moderately severe', less than half this number rated the case 'very severe' or 'less severe', one respondent rated the case 'life threatening'. Respondents commented on the forced separation of the child from its parents and the unavailability of the parent. One respondent warned of the 'addictive patterns of behaviour, cyclical repetitive behaviours', rating the case as 'very severe'. Another respondent commented on fourteen years of abuse, suggesting that 'it will take years for the psychological scars to heal'. The respondent who rated the case as 'life threatening' gave the long-term nature of the physical and emotional abuse as a rationale.

Case 7

Again the majority (19 out of 34 respondents) rated case 7 as 'moderately severe' utilising the severity of maltreatment classification provided, half of this number rated 'less severe' and 'very severe' respectively. Three respondents commented on the frequent verbal denigration and humiliation in the case study, as well as the fact that the violence in the case described did

not appear to be directed at case 7, and that there were no reports of sexual abuse or injuries from the physical abuse experienced. One respondent thought that early exposure to violence as a norm behaviour and would likely enhance such learnt behaviour and create an environment where a child would mimic such violent actions.

Similarly another respondent commented that:

> 'the self destruct mechanisms are in place quite early'

Another writing that the child:

> 'is brought up not knowing anything other than violence towards self and others'

However one respondent commented on the lack of clear evidence of abuse, other than that which comes from self-report.

Case 11

Nineteen of the respondents rated case 11 as 'very severe', half of this number rated the case as 'less severe' maltreatment. Many respondents in their rationale commented on the physical abuse by both the mother and father, coupled with the enforced isolation and neglect. Similarly there were a number of comments with regards to the child's stammer, enuresis, fire setting behaviour, familial abuse, lack of supports, burns inflicted and early onset conduct disorder as a variable associated with what respondents believed to be very severe or life threatening maltreatment. One respondent summarised the responses of many:

> 'there appears to be a lot of mental torture and oppression spanning a large portion of the developmental life of case 11, a wide range of abuse'

However one respondent, rating the case as 'moderately severe' believed the physical injury to be confined to one area, and no real evidence of sexual abuse to be evident.

Case 18

Twenty of the thirty-four respondents rated case 18 as 'moderately severe' with less than half that number rating the case as 'less severe' and 'very severe' respectively. No respondents thought the case information warranted a rating of 'life threatening'.

One respondent rating the case 'moderately severe' commented that the sexual abuse:

> 'was non penetrative sex, it was only masturbation'

Another respondent suggested that the case information evidenced sexual abuse only, no physical or emotional neglect was evident, and that the maltreatment as a consequence was not hugely severe. A number of respondents queried whether the urinary tract infection was a consequence of previous sexual abuse. Another respondent who rated the case as 'moderately severe' provided the following rationale:

> 'sexual attacks and promiscuity'

Case 23

The great majority of respondents (28 of the 34) rated case 23 'less severe', six respondents rated the case 'moderately severe'. The respondents variously indicated that their rating was as a consequence of the 'victim' having a degree of control over the situation described, that the action was aggressive but not violent, that it was a 'one off' experience, and that there appeared to be no permanent psychological damage. One respondent commented that the situation described was:

> 'an example of sexual awareness development and experimentation'

Another commenting that:

> 'at age 14 one has the ability to say no'

The fact that case 23 was 'witness to parental arguments' was considered to be 'less severe maltreatment to one respondent.

Case 26

The majority of ratings were almost equally split between 'moderately severe' and 'very severe' for case 26, with equal numbers of respondents (5 for both) rating the case as 'less severe' and 'life threatening'. A number of respondents commented that because a man who later received a prison sentence subjected case 26 to sexual abuse, then the severity of maltreatment rating must warrant 'very severe'. However one respondent, who rated the case as 'less severe' commented:

> 'I am not clear if the prison sentence was connected with case 26'

The respondents generally felt that evidence of posttraumatic stress disorder, flashbacks to the abuse, the young age at which abuse occurred, the blocking out of issues and the use of illicit substances, was indicative of unresolved issues. One respondent considered the ongoing psychological effect of sexual abuse in the case to be 'life threatening'.

Case 29

By far the majority of respondents (23 of the 34) rated case 29 as 'very severe' maltreatment. Less than half this amount thought the case to be 'moderately severe' in terms of maltreatment with only two rating the case as 'life threatening'. Those respondents who rated the case as 'very severe' focused on the prolonged and coercive sexual abuse, the victim having to masturbate other boys and provide oral sex, the isolative environment (being away from the

family) and the acceptance of bullying and sexual abuse as the norm. However one respondent who rated the case 'moderately severe' commented:

> 'other than the abuse at boarding school there is no evidence of physical or sexual abuse within the family or at home'

One respondent who thought the case 'life threatening' maltreatment gave the following rationale:

> 'continual, invasive, and would affect all of life'

Case 33

Just under half of the respondents thought the case warranted a rating of 'very severe' (15 of the 34), half of this number thought the case 'moderately severe'. Those rating the case as 'very severe' alluded to the destruction of trust because of father abuse, and the denial evident in the 'victim', indicating one who has not come to terms with abuse and who may be suffering isolation. Conversely one respondent rated the case as 'less severe', because of the denials. Regarding the sisters abuse, respondents commented how case 33 would have:

> 'likely been subject to the same abuse as the sister',

And of how

> 'emotional abuse was present when the sister was abused, either as a recipient or participant'

Three respondents chose not to rate the case, indicating that they felt there was insufficient detail.

Case 35

Twenty respondents thought the case to be 'life threatening', and fourteen rated the case as 'very severe' maltreatment. Those rating the case as 'life threatening' commented upon the prolonged abuse and reflection, the actual sexual intercourse, the repetition of severe abuse, which was sustained, and the voices', which are instructing case 35 to stab a child.

The ratings also appeared to be related to the apparent consent by the family to allow the abuse to occur, and the:

> 'complex family dynamics causing the victim to feel responsible for the actions of the perpetrators, potentiating guilt and trauma'

Case 40

The respondents were almost equally spilt in rating case 40, between 'moderately severe' and 'very severe', five respondents rating the case as 'life threatening'.

Many respondents highlighted the violence toward the pets evident within the case:

> 'pets were killed and there was serious assaultative behaviour'

> 'severe cruelty to pets, boiling water was thrown'

> 'destruction of animals was witnessed'

> 'if the father can do this to pets, why not to humans'

> 'seeing pets harmed intentionally is awful''

A number of comments concentrated on the prolonged exposure to physical and mental cruelty, one respondent provided the rationale:

> 'long periods of abuse during developmental years, the individual (case 40) only knows violence'

Case 47

The majority of respondents thought case 47 to be 'very severe' maltreatment (18 of the 34), eight respondents rated the case as 'moderately severe'. Six respondents rated the case as 'less severe' and two rated case 47 as 'life threatening'. Ratings of 'very severe' maltreatment appeared to be linked to the chaotic childhood evident in the case, and the failure to reach milestones. Some of the respondents who rated the case moderately and less severe questioned whether the 'allegations' made by case 47 had been substantiated, and whether they were proven. Similarly there were comments related to the 'little documented evidence' given for physical and emotional trauma, one respondent commenting that case 47 was 'attention seeking'.

However one respondent, rating the case as 'very severe', commented:

> 'there are both alleged and factual aspects, but this does not mean abuse did not happen'

Case 51

The majority of respondents (19 of the 34) rated the case as 'life threatening' maltreatment, eleven respondents rating the case as 'very severe'. Physical abuse, sexual abuse, self-mutilation, both parents being mentally ill, evidence of abuse from all carers and no avenues of support were all comments made regarding a rating of 'life threatening'.

Two respondents rating the case as 'very severe' commented as follows:

> 'there were a variety of inappropriate sexual partners'

'my main concern is emotional abuse, a lack of suitable role models'

One respondent, rating the case as 'moderately severe' gave the following rationale:

'there was sexual abuse by the father which was alleged but not specified'

Case 54

Seventeen respondents rated the case as 'very severe', eleven respondents thought the maltreatment to be 'moderately severe'. One respondent thought that sexual abuse throughout adolescence was a high indicator of future risk. Another respondent commented that:

'internalising feelings during long periods of abuse would likely have a profound effect on case 54s view of the self'

Another respondent similarly commented:

'the ongoing trauma of abuse would leave case 54 questioning him/her self'

Various comments alluded to case 54 coming to terms with his/her own sexual orientation, and the confusion with his/her own sexuality, and the inability to discuss issues. One respondent who rated the case as 'less severe' thought the case study contained insufficient information.

Case 58

Nineteen respondents thought the case warranted a rating of 'life threatening', fourteen thought the case to be 'very severe' maltreatment. Gross physical abuse, abandonment, rejection, sexual abuse over a long period, psychological damage, a history of severe neglect, considerable trauma and frequent denigration were all given as rationale for the ratings in this case. Respondents also queried whether sexual intercourse could be 'consenting' at age

twelve years, and expressed concern over the many disruptive placements, as well as concern as to why Social Services kept returning case 58 to an abusive and unsafe environment.

One respondent, rating the case as 'life threatening', commented thus:

> 'the worst so far, constant neglect as an infant, sexual abuse from an early age, a bleak outlook'

Case 64

Twenty-one respondents thought the case to be 'less severe' maltreatment, six respondents thought it to be 'moderately severe'. The remaining seven respondents thought the case warranted a rating of 'very severe'. Those who thought the case to be 'less severe' maltreatment variously commented:

> 'sexual contact at age 13 years is not severe'

> 'there is no evidence that abuse took place'

> 'there is no evidence of abuse'

> 'I have no problems with this encounter'

> 'Case 64 does not feel this to be abusive'

However those rating the case as 'very severe' maltreatment commented:

> 'despite not being viewed as abusive, the event with the babysitters was abusive'

> 'whatever case 64 thinks the babysitter contact was abusive'

'rape twice at age 13 years'

'actual penetration'

Case 72

Nineteen respondents rated case 72 as 'moderately severe', nine thought the case to be 'less severe' maltreatment, six respondents felt the case to be 'very severe' maltreatment. Those rating 'moderately severe' believed the frequency and intensity of physical abuse to be unclear, not prolonged, and that the child would not suffer too many 'after effects'. One who rated the case as 'less severe' commented:

> 'is this an over reaction to a strict upbringing. Is a child's perception of upbringing enough to describe it as abusive, was the father merely protecting and educating the children',

And similarly:

> 'the case appears to veer toward the unreasonably strict, as opposed to a true sense of abuse'

Case 86

Seventeen respondents rated case 86 as 'moderately severe' maltreatment, eight thought the maltreatment to be 'very severe', seven believed it to be 'less severe'. One respondent, providing the following as a rationale, gave a 'moderately severe' rating:

'sexual abuse on several occasions, frequent, and more than one perpetrator'

Similarly another respondent, rating in the same way commented:

'multiple abusers, likely to abuse others in later life'

Many respondents indicated that they were unclear as to what abuse had taken place, that the evidence was unclear, and that the abuse was 'implied' only.

One respondent, rating the case as 'less severe' commented thus:

> 'can you specify abuse at 3 or 4 years of age, I would suggest abuse did not occur, but is only a possibility'

However one respondent, rating the case as 'life threatening', identified sexual abuse as occurring at a young age, it being prolonged, and there being more than two perpetrators.

Case 92

Twelve respondents rated case 92 as 'moderately severe', nine as 'very severe', and nine as 'life threatening'. Those rating the case 'moderately severe' thought there to be gross neglect, but no evidence of physical or sexual abuse, and not that there had been serious neglect regarding nutrition. Another respondent commented that the mother had gone away in good faith, and it looked as if she took control on her return. Those who rated the case as 'life threatening' commented on the physical neglect and lack of supervision, parental abandonment, and the ongoing neglect.

Case 99

The respondents were almost equally split between rating case 99 as 'less severe' and 'moderately severe' (11 and 15 respectively) with six respondents rating the case as 'very severe'. Those rating the case as 'less severe' indicated that they thought the case illustrative of minor incidents of an infrequent nature, and no history of childhood physical or sexual abuse. However other respondents commented on the enforced isolation, failure to thrive, and of how case 99 was frequently deprived of love and affection. One respondent, rating the case as 'life threatening' suggested that severity of maltreatment was evident by case 99s placement on the child protection register.

Case 102

The respondents were almost equally split between rating case 102 as 'moderately severe' and 'very severe' (15 and 16 respectively). The respondents variously commented that abuse, in case 102, is alleged, that the case is not clearly defined, and that sexual abuse is not substantiated. However there were also comments related to there being no support networks, the 'ongoing frequent maltreatment', and one respondent who provided the following rationale:

> 'take an unhappy and unsettled child, and place in an environment which is more abusive that the one they have left. Good plan'

Case 108

Respondents were almost equally split between a 'less severe' rating of maltreatment and a 'moderately severe' rating for case 108. Four respondents rated the case 'very severe'. Whilst many respondents recognised long term psychological damage and prolonged exposure to violence and neglect, a lack of evidence for physical or sexual abuse, and a lack of direct abuse from the family was also recognised. One respondent thought there would be lasting psychological damage from the child witnessing an attempted stabbing by the mother against the father of the house.

Case 114

Similar to case 108 respondents were almost equally split between rating case 114 as 'less severe' and 'moderately severe'. Four respondents rated the case as 'very severe'. Respondents identified a confusing family atmosphere, emotional abuse, minor incidents, a lack of detailed evidence and a lack of clear definition in the detail of the case. However respondents also thought there to be long term psychological damage, particularly related to the length of time 'considerable tension' within the home environment had been endured.

Observations/themes evident in the Nurse Consultant Respondents (n=4) – Observations

There was complete agreement amongst the Nurse Consultants in rating two cases of maltreatment out of the 24 cases randomly selected. The Nurse Consultants agreed that both case 23 and case 114 constituted 'less severe' maltreatment. Nurse Consultants variously commented on case 23 as follows:

> 'case 23 experienced one incident of fondling, and exhibited a degree of control by leaving'
>
> 'aggression was evident but no violence, case 23 was fondled through clothing'
>
> 'there was no permanent physical or psychological damage'
>
> 'case 23 does not appear to be a victim of physical or sexual abuse'

Regarding case 114, the Nurse Consultants provided the following rationale for their ratings:

> 'a confusing family atmosphere, a sense of fear'
>
> 'emotional abuse, due to the severity of maltreatment classification, I can only rate as 'less severe'
>
> 'witnessed abuse and violence, therefore 'less severe''
>
> 'not clearly defined, no strong evidence of sexual, physical abuse, 'less severe'

On eleven occasions three of the four Nurse Consultants rated in the same way. This occurred in the rating of cases 3, 7, 11, 35, 47, 51, 64, 86, 92 and 99. In all eleven of these cases, save

three, the Nurse Consultant who rated in a dissimilar way to the other three rated either side of the majority rating. However in cases 35, 64 and 92 this fourth Nurse Consultant rating was two away from the majority rating.

Observations/themes evident in the benchmark Nurse and Nurse Consultants

The Nurse Consultants (n=4) rated cases 23 and 114 in the same way as the Benchmark Nurse (n=1), 'less severe' maltreatment. The rationale from the Benchmark Nurse related to case 23 revolved around the minor nature of the case described, the degree of content evident in case 23s description, and the apparent lack of long term damage, be it physical or psychological. The Benchmark Nurse rationale to the rating of 'less severe' for case 114 primarily related to the small amount of information in the case related to tension and conflict within the family, with no specific information related to neglect or physical, sexual or emotional abuse. Regarding the eleven occasions when three Nurse Consultants agreed with each other, the Benchmark Nurse rated similarly on seven occasions, (cases 3, 7, 11, 35, 51, 86 and 92). However, the Benchmark Nurse, on four occasions, where there was agreement amongst three Nurse Consultants, gave a different rating (cases 47, 54, 64 and 99). On only one occasion did the Benchmark Nurse agree with the fourth nurse consultant who had rated in a dissimilar manner to the agreeing three Nurse Consultants.

Observations and themes concerning specific respondents

Five respondents (2 Nurse Consultants and three Nurses) on twelve occasions chose not to provide a rating for a case, usually providing a rationale, which indicated that because of the lack of information they were unwilling to rate the case for severity of maltreatment suffered.

The following table is an indication of which respondents were unwilling to rate which case:

Table 12: Non-Rated/Missing Data within Maltreatment Questionnaire

Respondent	Case not rated
1	33, 102
2	5, 26, 33
13	33
28	114
31	33, 86, 99, 102, 113

Certain respondents provided rationale, which appeared to contradict rating. For instance respondent 4 rated case 86 as 'moderately severe', yet provided the following rationale:

> 'sexual abuse from an early age, multiple abusers in and out of the family, possibly likely to abuse others in adult life'

Similarly respondent 8 rated case 92 as 'moderately severe' maltreatment despite this rationale:

> 'emotional and physical depravation, physical abuse, sexual abuse, violence between parents is the norm'

As reported with those respondents who were not willing to rate certain cases, some thought the information provided about each case insufficient to enable a fully informed decision. This was typified in the comment by respondent 21, who suggested that because of the lack of specific information her responses were based on guess work and assumption, further indicating that she thought 'work experience' would make significant differences to the ways in which someone responds to the cases. Similarly respondent 1 commented on the 'paucity of specific information' regarding case 5, respondent 23 commenting on the lack of detailed evidence regarding case 24.

Many respondents tended to err on the side of caution, and a 'less severe' rating when certain words appeared in the case study text. For instance respondent 5 suggested that because abuse was 'suspected' in case 92, then the abuse was not actually proven, and therefore a rating of 'moderately severe' was given. Similarly respondent 9, and 27, both rated the self-reported regular sexual assaults of case 102 at age 12-13 years as 'moderately severe'.

The degree of disparity between rationale and ratings on a number of occasions, by a number of nurses, is evidenced perhaps of uncertainty and unfamiliarity with the use of rating scales. Nurses are not traditionally schooled in employing such scales systematically in their work, and evidenced a tendency to be somewhat conservative in their judgments, erring on the side of caution. This may be linked to the environment of medium secure hospitals, medico-legal environments where third parties readily utilise judgments made within the hospitals for their own purposes (in court proceedings for example). This perhaps contributes to the caution which the nurse exercises in documenting information and sharing their judgments in print. There may also be a degree of concern on the part of the nurse that in the event of their judgments being used to devise interventions, a subsequent failure to intervene (due to a lack of appropriately trained staff) would lead to a perception of the service as poor, or at least wanting. Table 13 is clearly indicative of nurses rating their own competency to judge severity of abuse as being majority *'neither agree nor disagree'*, a finding indicative of an unwillingness to commit to believing themselves to be either good or bad at rating this key clinical variable in forensic practice.

Certain cases are interesting in terms of the extremes of rating by respondents of the same case. Case 64 for instance involves a self-report of sexual contact with two babysitters who were 17 years of age. This 'contact' apparently involved sexual intercourse, the babysitters being in control, and confusion on the part of case 64, who also reports this to be a 'non abusive experience'. A further full sexual 'consenting relationship' occurred with a same age partner when case 64 was 14 years of age. Whilst respondent 4 records a rating of 'less severe' suggesting that the consequences of these encounters are not severe, respondent 7 feels that because actual penetration took place a rating of 'very severe' is warranted. Similarly respondents 1 and 2 feel that because intercourse took place the case warrants a 'very severe'

rating. However respondents 9, 12 and 16 feel that no abuse has taken place, no rape has been alleged against the perpetrators, and further that the victim does not feel the actions of the baby sitters to have been abusive. Respondents 9, 12 and 16 duly rated case 64 as 'less severe'.

Respondent 33 specifically gives his reasons for rating the case as 'moderately severe' as follows:

> 'I have rated this case as 'moderately severe' because the behaviours are perceived to be non abusive. The encounter at 14 years was perceived to be consenting, and using the Gillick Principle I have no problems with this encounter'

A similar extreme of rating occurs with case 96, which involves the mother leaving for America to secure work when case 96 was at a young age. She returns two years later to discover that her husband has failed to care for case 96 and siblings, providing little food, nor washing or cleaning and staying away from the home for days at a time. The ratings for this case range across all four of the categories, 'less severe', 'moderately severe', 'very severe' and 'life threatening'. Respondent 13 and 14 viewed the neglect in this case as being 'life threatening', whereas respondent 1 viewed the emotional abuse, restriction of food and care and ongoing neglect over the two years to be 'very severe' maltreatment. However respondent 4 whilst acknowledging gross neglect by the father in case 96, saw no evidence of physical or sexual abuse, and rated the case as 'moderately severe'. Respondent 5 began to suggest areas of discussion regarding case 96, which to him provided justification for his rating of 'less severe' maltreatment:

> '? The age of the children, and the ability to care for themselves, were the older siblings acting as substitute parents – an obvious lack of parental concern by mother and father – 2 years is a long time to leave the children and then feel concern. Did the father feel rejected and abandoned?, why did he stay away from home?, was he capable of providing for the physical and emotional requirements of the children?'

Respondent 26 suggests that the mother went away in 'good faith', and took control on return and would reassume a nurturing role, rating the case as 'moderately severe' maltreatment.

Case 33 is interesting also, in terms of the range of responses elicited as rationale for ratings of severity of maltreatment. Respondents used all of the range of severity of maltreatment, and four respondents chose not to provide a rating for the case. The case information reports that case 33s father used to sexually abuse the sister of case 33 whilst in the same room. Further to this the family reports that the father was close to case 33 in a way, which was beyond normal. The sister of case 33 (whilst resident in a secure unit) alleges that both her father and case 33 (whilst a child) abused her sexually. Case 33 denies such abuse, experienced or given. Those respondents who chose not to rate suggested that there was insufficient information, or because the severity of maltreatment scale did not allow for rating (see respondent 2). Some assumed that case 33 was not acknowledging the abuse by the father (respondents 3. 4. 5 and 11). Some believed that case 33 may have experienced the same abuse as the sister, rating the abuse as 'very severe' (respondents 14 and 16).

However some respondents chose not to believe the sisters allegations as described within the case information as indicated by the following comments:

> 'there is no real evidence of what abuse case 33 was subjected to. I doubt the validity of what the sister alleges as abuse'
>
> *(Respondent 17)*

> 'there is no evidence of abuse, fathers develop certain bonds with daughters and though her sister has made allegations about the two there could be an element of jealousy'
>
> *(Respondent 26)*

> 'there is no evidence of physical or sexual abuse, unless the allegations are correct'
>
> *(Respondent 23)*

Respondent 7 rated case 33 as 'life threatening', providing a two word rationale for their rating:

'incest alleged'

Respondent 8 identified abuse regardless of the truth, or otherwise, of allegations made by the sister by suggesting that there would likely have been 'emotional abuse by proxy' in case 33, rating the case as 'moderately severe' maltreatment.

Table 13: Nurse Respondents Self-Rating of Competency in Judging Severity: Rounded Means

	Mean
competency judgement 1	3
competency judgement 2	3
competency judgement 3	3
competency judgement 4	3
competency judgement 5	3
competency judgement 6	3
competency judgement 7	3
competency judgement 8	3
competency judgement 9	3
competency judgement 10	3
competency judgement 11	3
competency judgement 12	3
competency judgement 13	3
competency judgement 14	3
competency judgement 15	3
competency judgement 16	3
competency judgement 17	3
competency judgement 18	3
competency judgement 19	3
competency judgement 20	3
competency judgement 21	3
competency judgement 22	2
competency judgement 23	3
competency judgement 24	3

4:2 Results 111: Knowledge and Opinions Questionnaire: Descriptive Observations and Analyses

Descriptive Observations for Clinicians based in Medium Secure Units

Descriptive Observations

The sample size (n) was 34

90 copies of the questionnaire (see Appendix Six) had been distributed to a range of Professional Staff in each of the three medium secure environments. The response rate was therefore 37.7%.

The mean years of service for those in the sample was 12.59 years, with a standard deviation of 7.91 years (95% confidence interval for the mean 9.83, 15.35)

The gender split for the sample was 17 males (50%) and 17 Females (50%).

The sample comprised 10 (29.4%) Psychiatrists; 3 (8.8%) Social Workers; 5 (14.7%) Occupational Therapists; 2 (5.9%) Psychologists; and 14 (41.2%) Nurses.

The sample comprised 32 (94.1%) who had worked with those who had been abused; 2 (5.9%) for those who had not worked with those who had been abused.

The sample comprised 13 (38.2%) involved in a previous violent incident (past 12 months); 21 (61.8%) for those who had not been involved in a violent incident.

Questionnaire for Clinicians Based in Medium Secure Units (see Appendix Six)

Themes of Focus for the Respondents

This section will examine a range of key themes emerging from the questionnaire, related to the rationale provided by the respondents (n=34) for their agreement/ non-agreement to a list of statements (for list of statements please see Appendix Six). The themes have been broken down by professional group responses, as well as an overview of general themes generated by the respondent group as a whole. This enables an examination of the differences between the knowledge base of professional groups, particularly in the use of research literature in supporting clinical judgments that they make.

Professional Groups

Psychiatrists n= 10

2 of the respondents within this group provided no rationale for their answers to statements 1-15.

Statement 1

There appeared to be general agreement, many indicating that insight was considered to be a key factor in discontinuity of abusive behaviours.

Statement 2

Mixed responses indicated that many thought research was improving, via the use of better control groups for instance, whilst others recognised definitional and other methodological problems.

Statement 3

Whilst there was recognition of a split regarding the forms of violence practiced by the different gender groups (i.e. inward self destructive violence from females) there was also recognition of the need for more research to be conducted regarding female violent behaviour amongst females. Many commented on their belief that males were more likely to be violent generally. One respondent did not recognise any equation between childhood sexual abuse and later violent behaviour.

Statement 4

Mixed responses were evident to statement four. The rationale for disagreement included the unknown number of those who have been abused, and the statement that conduct disorder was a strong predictor of violence. However, the respondent indicated a lack of awareness of abuse being a strong predictor. Those agreeing with the statement cited clinical experience and their knowledge of the research as the basis of their rationale, and further that violent behaviour is 'learnt behaviour' and the result of 'underlying anger'.

Statement 5

There was general agreement among the Psychiatrists in response to this statement, many indicating that they knew the research to be supportive of Schizophrenia being associated with violent behaviour, as compared to other disordered groups.
Comments included:

'When active, schizophrenia does seem to modestly increase the risk'
'There is evidence but the effect is only small'
'I am aware that some schizophrenics are more violent'

However, the agreement was not unanimous, a lack of agreement was evident in some of the Psychiatrists who felt that personality disordered individuals were more likely to behave in a violent manner, as were substance abusers.

Statement 6

Mixed responses were evident in relation to statement six also, although there was more agreement than not that children are best brought up in their natural families.

Comments included:

> 'A natural, abusive family is not good'
>
> 'In the majority of cases I would agree, but not if a history or a cycle of abuse was evident'

Statement 7

Mostly there was disagreement with the statement, respondents variously indicating their understanding of the multiple causes of violent behaviour, of violence as a social dynamic, and of how environmental forces are as important as generic pre -determination.

Statement 8

Respondents leaned somewhat toward agreement, with responses such as: 'this appears to be so', and 'this appears a logical conclusion'. Others indicated that they were unsure of the evidence, and of how there was, 'no evidence of a linear relationship'.

Statement 9

Mixed responses were evident as well as cautious responses revolving around the use of the word 'irretrievably'. One respondent disagreed with the statement, citing Paul Mullen's work as the rationale for the rationale. The following statement exemplified the cautious response:

> 'Usually so, but not always, if protective factors exist, or if maltreatment is not prolonged'

This response appears to have been informed by the literature in this area.

Statement 10

The respondents almost all disagreed with this statement identifying that:

'there are multifactorial causes for such associations'

'the mentally ill usually commit minor offences'

'Association does not prove causality',

And of how:

> 'poverty and social deprivation are much more important than mental illness, which actually accounts for a small number of offences'

However, some indicated their belief in a link between mental illness and criminal behaviour, and acknowledged that the mentally ill were more likely to be apprehended.

Statement 11

Almost total disagreement to this statement was evident among respondents, who variously cited clinical experience, and the high number of patients who have been abused, as the rationale for their response. One respondent commented on the greater frequency of borderline personality disorder and post traumatic stress disorder, amongst those who have been abused, another commenting on how 'abuse obviously leads to distress and disorder in most individuals'.

Statement 12

There was agreement amongst all respondents that clinicians can play a part in planning interventions, to prevent recurrence of abusive child rearing patterns. However, a number of respondents indicated that this process should be in collaboration with other professional groups, with a greater emphasis on the public health perspective.

Statement 13

The figure of three quarters of those abused in childhood going on to violently offend, was felt by many to be unsupported by the evidence. Many felt that the figure appeared high or indicated that they were unsure of the research. However one respondent whilst commenting that he thought the figure to be lower than in the statement qualified the comment thus:

'violence is rare, abuse is, unfortunately common'

Statement 14

A mixed response generally with comments as follows:

'I am not familiar with the research on primary prevention'
'Practical considerations may account for this'
'Research on prevention is difficult'

Statement 15

Almost unanimous agreement was evident in responses to the statement related to parents exhibiting violence as a continuum of behaviour, they themselves have experienced. Comments revolved around the modeling of behaviour by parents and the impact of learnt behaviour, and of how violence is a continuum motivated by social learning.

Nurses n = 14.

All of the respondents within this group provided a rationale for answers to statements 1- 15.

Statement 1

The Nurse respondents almost all agreed that in recognising and rejecting abuse suffered in their own childhood, adults would be better prepared to break abusive behaviour patterns.

Respondents cited the learning of more acceptable behaviours, and the formation of coping mechanisms as key to this process. One respondent who agreed with the statement reflected for personal experience, her two 'brothers' having been fostered into her family after periods of abuse within their natural family. She (the Nurse) indicated how the boys had been able to move on in their lives, but how she frequently encounters those in the clinical setting for whom the cycle of abuse has continued.

One respondent who disagreed with the statement commented:

> 'To recognise and accept (as opposed to reject) would more likely assist in breaking patterns of abuse'

Statement 2

Almost all indicated that they neither agreed nor disagreed with the statement, indicating that they had no evidence or knowledge of the research to answer any other way. One respondent who answered in this way reflected on how it was important to examine both the methods used, and further examine the ways in which the results of research are contextualised.

Statement 3

Again, many indicated that they neither agreed nor disagreed with statement three. However, a similar number disagreed, indicating that they thought the statement was true of 'violence to others', but that equal numbers of females direct violence against themselves. Another respondent reflected how there was a gender difference in violent behaviour, with externalised violence often viewed as more socially unacceptable. A respondent, agreeing with the statement, wrote that the research indicates that people who have been abused are likely to become abusers themselves.

Another respondent who agreed with the statement gave the following rationale:

> 'Conditioning in society predisposes more males to violence as a consequence of emotional distress. Based on sexual abuse being more prevalent in females, but the population of secure/prison females being less in number than males, I conclude that they (females) are more likely to display violence toward self and others'

Statement 4

Almost all agreed with the statement:

> 'Evidence of abuse in childhood is a strong predictor of adult violent behaviour'

However, 5 respondents were cautious in their agreement, providing a range of comments such as:

'I believe this to be true'

'I would presume, but I know of no evidence in my experience'

'Dependent on level and type of abuse'

One respondent, who agreed, indicated that during her psychiatric career she had found that patients with a supportive caring family were more rare than those with an abusive one.

One respondent who disagreed commented that it was by no means inevitable that abused individuals will engage in violence, however this comment was qualified thus:

> 'That is not to say that those who are violent have not been abused'

Statement 5

There was a mixed response regarding statement five:

> 'Schizophrenics are more likely to commit violent offences than other disordered groups'

Slightly more disagreed with the statement than agreed, a number suggesting that those with Schizophrenia are more likely to self-harm than other groups. A number of respondents who disagreed, appeared to provide a rationale which indicated that they were comparing those with schizophrenia not to 'other disordered groups', but to the general public:

> 'Few Schizophrenics have committed violent offences compared to the general public',

And

> 'many live their lives without offending, a minority of Schizophrenics became offenders'

One respondent, who despite disagreeing with the statement, suggested that delusions were more predictive of violent behaviour, 'particularly when related to paranoia'. One respondent who disagreed suggested that within her own clinical experience she had:

> 'found a greater propensity to violence amongst those with personality disorder'.

Amongst those who agreed with the statement, many indicated that the literature and research was supportive of the rationale for their answers. Comments in this latter group included the following:

> 'Research proves this, dependent upon hallucination or psychotic experience',

And

> 'Only due to the disorganised features of the disease rather than through any planning process'

Statement 6

The responses to whether 'children are best brought up in their natural families' were mixed, with rationale revolving around qualification such as:

> 'It depends how dysfunctional the family is'
> 'This is circumstantial and depends upon parenting skills'

One respondent, who disagreed with the statement, commented:

> 'Abusive natural families are not necessarily better than fostering, adopting well adjusted families'

Neither agreeing or disagreeing with the statement one respondent rephrased the statement completely to:

> 'Children are best brought up in loving stable relationships'

Statement 7

Responses were also mixed to statement seven, many feeling that whilst genetics and head injuries were associated with violent behaviour, 'learnt behaviour' and 'upbringing' also played a part. Many discounted an age range as important, suggesting that head injury at any age may determine adverse or violent behaviour.

Statement 8

In a series of mixed responses to statement eight, Nurses indicated that they believed that severity can only be determined by those who have been abused, that peer group pressure is similarly associated (compared to severity of abuse in childhood) with later levels of violence and that the association may 'sometimes' occur. One respondent, in agreeing with the

statement commented on how less severe abuse can still be traumatic, and of how in clinical experience:

> 'Many of my encounters with those having committed, severe offences indicate horrific abuse in childhood'

Statement 9

Many of the respondents commented on the use of the word 'irretrievably' in statement nine, disagreeing that severe maltreatment would irretrievably damage an individual's personality. One respondent suggested substituting 'alter' for the word 'damage' in the statement, another asked for further definitions of 'minor or severe maltreatment'. Those agreeing with the statement gave rationale, which included:

> 'Empirical evidence supports this'

And a belief that:

> 'there will always be residual damage, some people retaining bad memories of maltreatment'

Statement 10

There was a tendency for Nurses to disagree with this statement, providing rationale, which revolved around mentally disordered offenders being more likely to be detected, and mental disorder being a result of the penal system or being incarcerated. Those respondents who agreed with the statement suggested that mentally ill individuals have different perceptions of rules, and that there may be a casual link, but that this was due to the disorganised state that some mental illnesses can produce. One respondent, who disagreed with the statement, commented thus:

> 'there is an association, not a causal link'

Statement 11

Again the Nurses tended to disagree with the statement, suggesting that residual feelings of guilt rejection and confusion remain into adulthood (by those who have been abused in childhood). Similarly, one respondent felt that the trauma of abuse was a significant trigger, but not the only one. Another respondent, who whilst agreeing with the statement, further indicated that clinical experience, whilst working as a therapist, revealed high post traumatic stress disorder in rape survivors, 'the stress being irrelevant of the when'. (referring to when the abuse occurred).

Statement 12

There was unanimous agreement that clinicians can play a part in planning interventions to prevent recurrence of abusive child rearing patterns. Comments included:

> 'I don't think abusers want to become abusers, but aggression may be the only way they know to relieve anger and frustration. It is possible to teach alternative ways of coping'
>
> 'I could not continue in my profession if I did not believe this, but influences other than clinical can contribute to bringing about such change'

Respondents also commented on the importance of appropriate training, and early intervention.

Statement 13

Respondents either disagreed or indicated that they neither agreed nor disagreed with statement thirteen. Many provided a rationale for their answer related to not knowing enough about the subject, or not being aware of the statistics in this area. One respondent commented on the 'abused number who do not come into contact with the law', another thought the figure would be high, but perhaps not as high as in the statement.

Statement 14

There was general agreement with statement fourteen, however, the rationale provided indicated that some respondents felt that they were not as up to date with the research as they should be. One Nurse commented 'this appears to be a psychiatric research trait, reactive as opposed to proactive. Primary health care research lacks any mental health focus'.

Statement 15

All respondents agreed with the statement that many parents exhibit violence as a continuum of behaviour they themselves have experienced. The Nurses variously cited clinical experience and research as supporting the statement. A number of respondents reflected upon the importance of learning, and acquiring skills of coping with both anger and frustration.

Occupational Therapists (n=5)

One of the respondents in this group provided no rationale for their answers to statements 1-15.

Statement 1

Almost all of the respondents agreed with the statement, one respondent reported that they did not understand the question. Those in agreement felt that recognition and rejection of abuse went some way to solving the problems associated with childhood abuse, and that rejecting the abuse, and the reasoning behind it, would reduce the likeliness of them exhibiting similar abusive behaviour. However, one respondent, whilst agreeing, felt that the word 'reject' in the statement appears to negate the notion of recognition.

Statement 2

Again, almost all agreed with statement two, one respondent neither agreeing nor disagreeing, providing a rationale which suggested that little was known of the research or methodologies

used in this area. The respondents who agreed with the statement felt that ethical problems and, taboos and sensitivities accounted for methodological problems associated with researching abuse in childhood and adolescence.

Statement 3

The respondents provided mixed responses to statement three. Those in agreement with the statement recognised a gender split in violence, one respondent commenting:

> 'Some research makes links between the different presentations of males and females after abuse, e.g.. - very crudely, men externalise violence, women internalise through self harm'

One respondent who disagreed provided a rationale indicating that she wished to disagree with stereotyped views of women internalising anger and men externalising anger and frustration. The respondent commented that this rationale was given regardless of research, which may provide evidence contrary to this view.

Statement 4

There were mixed responses to statement four that 'evidence of abuse in childhood or adolescence is a strong predictor of adult violent behaviour'.
Comments included:

> "There is no clear causal link".

> "A probable correlation, learnt patterns of behaviour".

> "I don't think its fair to say that because an individual has experienced abuse in childhood they will automatically be violent adults. Not all abused children grow up to be violent".

Statement 5

Responses were divided between disagreement and neither agreement nor disagreement. Those who disagreed with the statement felt that the evidence did not support the statement, and one respondent felt that Schizophrenics posed a greater risk to themselves than others. The other respondents commented that they did not know enough about Schizophrenia to agree or disagree with the statement.

Statement 6

There were mixed responses to statement six, all respondents indicating the importance of circumstance, and suggesting that a loving supportive environment was more important than a natural or adoptive/fostering family.

Statement 7

The Occupational Therapists generally disagreed with statement seven, commenting that violent behaviour had a multifactorial aetiology, and that violence may be caused by environmental circumstances by age 14.

Statement 8

The respondents generally disagreed with statement eight, variously commenting that they did not think severity of abuse and violent behaviour to be correlated, and that some who have been severely abused may not exhibit any violent behaviour. One respondent, who disagreed, felt that the level of support given to an individual can allow a person to cope with a large amount of abuse, or conversely cause a person to cope poorly, who may have experienced a small amount of abuse.

Statement 9

Almost all respondents disagreed with statement nine, commenting that a causal link between severe maltreatment in childhood and irretrievable personality damage in adulthood had not been established. A respondent, who disagreed, commented that with appropriate support severe maltreatment could be overcome, in terms of its impact in adulthood. Another respondent remarked on how unlikely the association was, providing the following as rationale:

> 'Given the statistics on the numbers who have been abused relative to those who have irretrievably damaged personalities'

Statement 10

There was unanimous disagreement with statement ten, which suggested that the high proportion of mental disorder in offender populations was evidence of a causal link between mental illness and criminality. One respondent felt that the inference of the link was not the same as it being 'causal', another felt that substance abuse was linked to mental illness. One respondent suggested that a comparison would have to be made to the number of mentally ill people who do not commit crimes, and the number of individuals who commit crimes but are not mentally ill, before an agreement with the statement could be given.

Statement 11

Two of the respondents disagreed with the statement, and one who neither agreed, nor disagreed indicated an inclination to disagree. One respondent, who disagreed, suggested that 'mental distress', as used in the statement, covers a wide range of presentations, another commented that there would likely be a high risk of mental disorder in the absence of treatment and support. The Occupational Therapists who agreed with the statement commented that it was reasonable to assume that more people who have been abused suffer mental illness, than those who have not. However, the respondent cautiously suggested that there are also many other causal factors associated with mental illness.

Statement 12

The occupational therapists agreed unanimously that clinicians could play a part in planning interventions to prevent recurrence of abusive child rearing patterns. They variously suggested the usefulness of cognitive approaches and the use of 'appropriate skills' to prevent abusive patterns of child rearing.

Statement 13

The respondents tended to neither agree nor disagree with the statement, indicating that they were unaware of the figures or statistics in this area. However, one comment, whilst neither agreeing nor disagreeing was as follows:

> "I don't know the statistics, but three quarters seems high. It very well could be this figure though".

Statement 14

Generally a mixed response, suggesting that the statement was 'a likely supposition', and that the statement indicated a situation, which was 'probably the case'.

Statement 15

There was a general agreement with statement fifteen among the Occupational Therapists who felt that many parents do exhibit violence as a continuum of behaviour they themselves have experienced. Whilst agreeing with the statement, one respondent commented:

> 'Unless the circle is broken by an awareness of the need to change'

Two respondents reflected on the importance of behaviour having been modelled by parents, and the process of social learning in the cycle of behaviour, parent to child.

Social Workers n=3

One of the respondents within this group provided no rationale for answers given to statements 1-15.

Statement 1

The respondents disagreed with each other regarding this statement, one suggesting that it is possible to reframe and recognise the past, the other commenting on how:

> 'A high degree of learnt behaviour is difficult to break when individuals are in a cycle of abuse'

Statement 2

The respondents neither agreed or disagreed with statement two, however, one respondent suggested that research in the area of childhood and adolescence abuse was weak, but was not qualified enough to say why.

Statement 3

In neither agreeing nor disagreeing with the statement, one respondent asked for a definition of violence, and suggested that there was a gender difference in the expression of violence regardless of abuse history.

Statement 4

A mixed response, one respondent suggesting that abuse in childhood would be a good measure of the risks of adult violent behaviour. The other respondent was more cautious however, commenting:

> 'I don't know, but these seem to be associated with continued distress and dysfunction in adulthood, which can be associated with violence'

Statement 5

One respondent neither agreed nor disagreed with statement five, but suggested that it was not entirely true, commenting:

> 'Not entirely true as most persons suffering mental illness are afraid of others. However, when a combination includes paranoia toward others then the risk of offending increases'

The other Social Worker disagreed with the statement, suggesting a strong media bias, and of how the majority of those with Schizophrenia are not violent to others.

Statement 6

In agreeing with statement six, that 'child are best brought up in their natural families', one Social Worker commented upon how alternatives (multiple placements) are often poorly administered. The other respondent neither agreed nor disagreed, but suggested that the statement was not necessarily true, and of how quality substitute families were better than abusive families.

Statement 7

Both respondents disagreed with the statement, citing environmental factors as an important predisposing factor to violent behaviour.

Statement 8

The respondents gave different responses to statement eight. One agreed with the statement suggesting that as 'learnt behaviour such responses are reinforced'. The other respondent disagreed commenting that this equation was not proven, and further asking about the concept of severity, whether it was the victim's concept and understanding, or the researchers.

Statement 9

Both tended to agree that severe maltreatment will irretrievably damage an individuals personality, commenting on the difficulty of measuring other variables. One Social Worker commented thus:

> 'Such experiences create the basis for maladaptive behaviour, and individuals adopt a flight or fright attitude as a means of survival, behavioural boundaries become distorted, as acceptable behaviour is never learnt'

Statement 10

One respondent agreed, the other neither agreed nor disagreed. The Social Worker who agreed suggested that to a high degree, mental illness is triggered by alcohol or illicit substance use, causing a circular effect of crime to meet need. The other respondent thought the statement to be evidence of the exclusion behaviour and criteria of society in general.

Statement 11

Both Social Workers neither agreed nor disagreed with statement eleven. One however commented that he had a lot of clients who had been maltreated as children.

Statement 12

Cautious responses were given to statement twelve. The Social Worker who agreed with the statement qualified his agreement by writing:

> 'Depending on evidence proving we can help'

The other Social Worker neither agreeing nor disagreeing with the statement thought this area difficult to quantify.

Statement 13

Respondents neither agreed nor disagreed commenting that they did not know how this could be measured.

Statement 14

One respondent agreed that there was a disproportionate amount of research conducted in favour of post abuse treatment of families and children (as opposed to research or prevention).

However this agreement was qualified with the comment:

> 'This is just an impression, I have no evidence'

The other respondent neither agreed nor disagreed with the statement.

Statement 15

Both Social Workers agreed with statement fifteen, commenting upon adults exhibiting attitudes and beliefs as a continuum of traits brought from earlier experiences.

Psychologists (n=2)

Both respondents within this group provided a rationale for answers to statements 1-15.

Statement 1

One Psychologist agreed with the statement, qualifying agreement with the comment:

> 'If I read correctly, and the person perceives their abuse as destructive to life and would be less inclined to report the process'

The other Psychologist was more cautious, neither agreeing nor disagreeing suggesting that recognition is not understanding of the potential impact, reminding us of the importance of the emotional legacy.

Statement 2

One respondent neither agreed nor disagreed, but commented that the research in this area had improved markedly. The other respondent agreed with the statement suggesting that information gathering was difficult in this area, and of how rationalising the impact of abuse suffered can lead to distorted reporting.

Statement 3

There was strong disagreement with statement three by both psychologists who commented:

'The violence may be different in direction but the level can be equal',

and

'Research does not support this statement'

Statement 4

One respondent disagreed with the statement, commenting that if a victim, then the relationship is not strong, but if the abuse is sexual then such abuse can be a predictor of adult sexual abuse. The other respondent neither agreed nor disagreed, indicating a lack of awareness of the research as a rationale for the answer.

Statement 5

There was both agreement and disagreement to statement five,:

> 'Schizophrenics are more likely to commit violent offences than other disordered groups'.

The psychologist who agreed with the statement commented that 'research supports this:

> 'Evidence is = less incidence, but when they do it's often severe and against close relatives'

Statement 6

Both Psychologists neither agreed nor disagreed with the statement, commenting upon circumstance and the functioning of the family.

Statement 7

Again both Psychologists neither agreed nor disagreed with the statement suggesting that head injury at any age can lead to violent behaviour.

Statement 8

One respondent neither agreed nor disagreed, suggesting that the statement was a generalisation, the other respondent disagreed with the statement providing no rationale.

Statement 9

In disagreeing with the statement, one respondent commented on severe maltreatment in childhood' irretrievably damaging personality thus:

> 'Not always, depends on support systems, what models are available, much damage is retrievable'

The other respondent neither agreed nor disagreed with the statement.

Statement 10

Both Psychologists disagreed with the statement, indicating that research did not support the statement and of how:

> 'People with a psychotic illness often show a pre morbid history of criminality'

Statement 11

Both Psychologists disagreed with the statement, one provided no rationale, the other commented:

> 'I do not know the research, but just feel that the statement is incorrect'

Statement 12

Both Psychologists agreed with the statement, suggesting that clinicians are able to provide individuals with parenting skills and supervision.

Statement 13

Both respondents indicated that they were unaware of the research to support the statement of three quarters of those abused in childhood going on to violently offend. However one respondent recorded a disagreement with the statement, the other neither agreed nor disagreed.

Statement 14

One Psychologist, in agreeing with the statement, indicated that the research was still identifying the impact of abuse, and this was required before pre-empting abuse and abusive families. The other Psychologist in this small group related that both areas were important, research on prevention decreasing the need for post abuse treatment.

Statement 15

Both Psychologists agreed with the statement, neither providing a rationale for their answer.

Key Themes of Focus

A number of key themes emerged from the rationale provided by the respondents n=34, these include:

- Definitional problems associated with the area of childhood/adolescent abuse, particularly regarding the terms 'violence' and 'severity'.
- The belief that those individuals with Schizophrenia pose a risk of harming themselves.
- The circumstantial nature of the work in the area of child maltreatment, and the tendency to generalise.
- A recognition of the residual guilt, shame, and psychological damage experienced by those who have been abused.
- The belief that clinicians can play a significant part in planning interventions to prevent recurrence of abusive child rearing patterns.
- The belief that abuse is common in forensic populations, violence being exhibited as a continuum of behaviour individuals themselves have experienced.

It is possible to determine a range of positive and negative observations from the rationale provided by the clinicians (n=34).

Table 14: Themed Analysis of Rationale: Negative and Positive Observations

Positive Observations	Negative Observations
• The recognition of insight as a key feature of discontinuity • How the development of coping mechanisms can assist in breaking patterns of abuse • The understanding of gender difference in the presentations of violent behaviour • The wealth of clinical experience in working with those who have been abused • The understanding of the multiple causes of violent behaviour and mental illness	• How little is known regarding the evidence base or research in the area of childhood abuse and neglect • The need for training and preparation to work with this client group • The frequency (high) with which clinicians encounter abuse histories • The difficulty encountered in researching this area, taboos and sensitivities limiting the research base • The knowledge base regarding Schizophrenia • The negative effect of incarceration/prison on an individuals mental state

Table 15: Professional Groups (n=34) Mean Levels of Agreement: Knowledge and Opinion questionnaire

Agreement Questions	Rounded Mean
1) Adults who recognise and reject abuse suffered in their own childhood are more likely to break patterns of abuse behaviour in which they are involved.	4
2) Research into the area of abuse for childhood / adolescence is weak because of the many methodological problems associated with such work.	3
3) Sexually abused males are more likely to engage in violent behaviours in later life than sexually abused females.	3
4) Evidence of abuse in childhood or adolescence is a strong predictor of adult violent behaviour.	3
5) Schizophrenics are more likely to commit violent offences than other disordered groups.	4
6) Children are best brought up in their natural families.	3
7) Violence is pre-determined by biological causes, (such as genetic predisposition, or head injury), before the age of 14.	4
8) The severity of abuse suffered in childhood/ adolescence is associated with the level of violence exhibited by adults who engage in such behaviour.	3
9) Severe maltreatment in childhood/ adolescence will irretrievably damage an individual's personality.	3
10) The high proportion of mental disorder in offender populations (as opposed to the general population) is evidence of a causal link between mental illness and criminality.	4
11) Mental disorder/distress is no more prevalent in Adults who have been abused in childhood / adolescence than in adults who have not been abused.	3
12) Clinicians can play a part in planning interventions to prevent recurrence of abusive child rearing patterns.	4
13) It is likely that three quarters, or more, of those abused in childhood or adolescence, will go on to violently offend.	4
14) There is a disproportionate amount of research conducted in favour of post-abuse treatment of families and children, as opposed to research on prevention.	2
15) Many parents exhibit violence as a continuum of behaviour they themselves have experienced.	2

Please Refer to Appendix 15

One-Way Analysis of Variance Results for Mean Agreement Levels by Profession

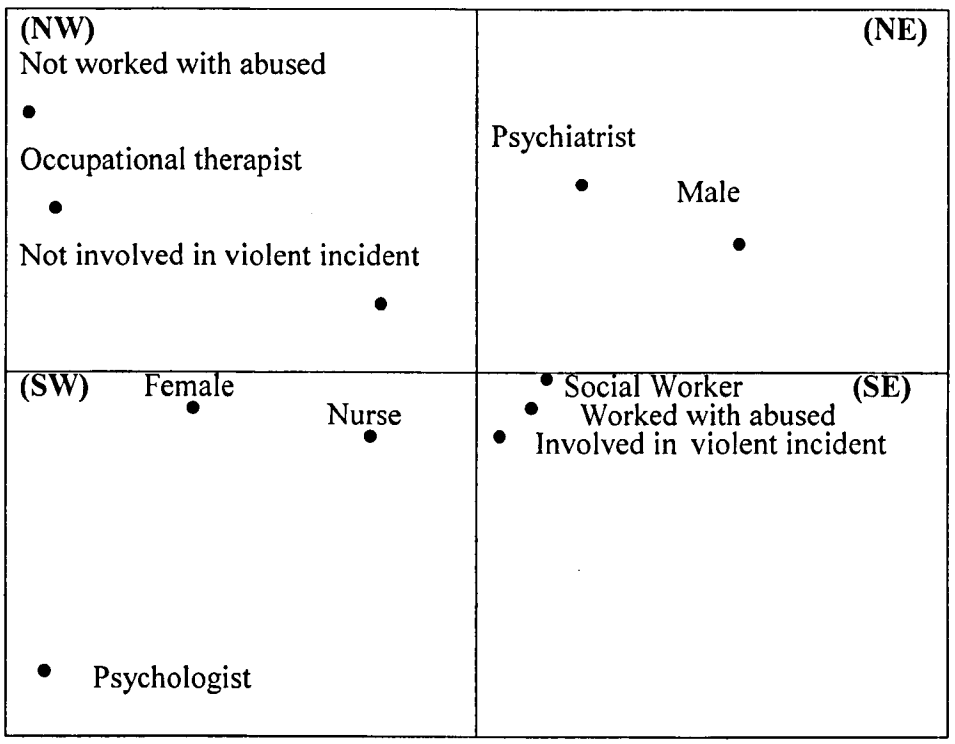
All tests supported the Null hypothesis i.e. there is no difference in mean levels of agreement when factored by the variable profession. ***Please Refer to Appendix 16***

It would appear that differences between given rationale for agreement/non agreement among professional groups is marked for certain professionals, Psychiatrists in particular. Psychiatrists were clearly using research literature to inform their decisions much more than other professional groups. This in marked contrast to social workers and occupational therapists for instance, who readily suggested that they were unfamiliar with the literature in a range of areas. A positive theme, which ran throughout all professional groups, was a genuine concern for the abused client group, however an informed workforce is the expectation of both the patients and the public, not merely concern. Psychiatrists do have a longer tradition of utilising both research and evidence based practice, and academic psychiatry was the first academic arm of forensic practice to be established, this perhaps explaining some of the findings in this area. However there are clear concerns in the ways in which clinicians, other than Psychiatrists, readily admitted to a poor knowledge and awareness of the evidence base in areas such as schizophrenia and violence, whilst working professionally in a forensic environment. The scope for 'targeted' evidence based practice initiatives within secure settings is evident from such findings. The need to develop a more rigorous forensic educational programme has been alluded to earlier in this work, and there is clearly an indication for such programmes to be targeted at specific professional groups.

A further analysis was undertaken of the categorical data recorded in the knowledge and opinions questionnaire (see Results III). Homogeneity analysis (or Homals) is undertaken to describe relationships between two or more nominal variables using spatial distance as a key to association between variables. Because linear relationships do not always hold between the variables examined in this aspect of the study, homogeneity analysis can be a useful display of the relationships revealed in this study between the variables of profession, having worked with abused patients, having been involved in a violent incident and gender. The usefulness of such a display (see Diagram 2) is in further profiling the staff group working within MSU's, particularly in terms of professional groups relationships with gender, and having worked with abused clients.

In Diagram 2 the homogeneity analysis has been broken down into four quadrants to further illustrate the association between variables. The four quadrants correspond to compass points, North West (NW), North East (NE), South West (SW) and South East (SE) for ease of reference. Such a diagram illustrating these associations may be drawn as follows:

Diagram 2: Homogeneity Analysis for Nominal Variables/ Association Diagram



Chapter Five: Discussion

5.0 Introduction

This chapter will utilise a framework for the discussion of this study, which reflects both the aims of the work, outlined in Chapter One, as well as methodological issues and concerns, outlined in Chapter Three. The first part of the discussion will revolve around the abilities and confidence of nursing staff in working with patients who have been abused in childhood and/or adolescence. In reflecting upon core skills of the FMHN, as described in the literature, the consistency of clinical decision making among nurse and Nurse Consultant respondents against a Benchmark nurse will be discussed. Notions of expert practice, related to the role of Nurse Consultants will also be discussed in the context of this research, as well as what findings mean in terms of FMHN's, and other professional staffs development.

The environmental constraints involved in this study will form the basis of further discussion and review, not only in terms of access, but also in terms of researching this particular client group within a medico-legal context. A discussion of the advantages of using certain operational definitions, a combined methodology, and association analysis will also be included within the chapter. A reflection upon the usefulness, purpose and relevance of this study will run throughout the discussion.

5.1 Abuse/ Maltreatment Study

The skills of working with victims of abuse, intervening with and supporting victims, have been identified to be core skills of the forensic mental health nurse (see Chaloner 2000, Tarbuck 1994). In developing specialist and advanced practice certain Universities in England established courses of development, which reflected some of these core skills (see Chapter Two). Unfortunately the development of such educational packages does not appear to have been adopted widely in terms of continuing professional development (CPD). This study revealed that in a sample of forensic mental health nurses (FMHN's) (n=34) just over one third (35.3%) had post-registration qualifications, and that only 23.5% of the sample had forensic based post-registration qualifications (see Chapter Four, Results II). These findings,

albeit descriptive, are worrying to an extent, considering that the upper age range was 30 plus, with 35.3% of the sample aged 40 years and over, with the majority of respondents having 10 or more years experience. These figures, whilst not as high, mirror the figures revealed by Storey and Dales (1999) survey of forensic environments and nursing staff. This survey (ibid.) identified that 60% of the staff in secure mental health care environments had no post-registration qualifications. The authors (ibid.) further recognised that in forensic hospital environments CPD was recognised as ad-hoc, some practitioners receiving a great deal of development, while others received none. Similarly the Storey and Dale (1999) survey revealed limited evidence for post-registration educational courses improving competence for working in secure environments. The only examples of such improvement being cited in this survey (ibid.) were related to the Thorn Cognitive Behaviour Therapies and Psychological Interventions Programme (see Chapter Two). This situation was not confined to the United Kingdom however, Kettles (2001) examining perceptions of forensic nursing in eight countries, observing a general feeling that nurses were being asked to become more expert without the benefit of training and education (see Chapter Two). Descriptive observations within this study (Chapter Four, Results II) concerning the nurse sample (n=34), reveals an older workforce, with over half (55.9%) having ten years or more work experience. It is perhaps unsurprising that the 67.6% of this sample have an RMN as their registration qualification, with only 5.9% of the respondents having a degree as their registration qualification. It would appear that the higher proportion of this sample (n=34) registered in a time prior to degrees or diplomas being offered to qualifying nurses. Of the sub sample with post-registration qualifications only thirteen (38.2%) had qualifications, which were beyond what might be considered basic post-registration study (this figure includes four Nurse Consultants and the Benchmark Nurse also surveyed) (see Chapter Four, Results II). The most recent large-scale survey of medium secure environments (DoH 2000/2001) indicates that 85.2% of NHS medium secure facilities were not fully staffed. It is acknowledged within this report (ibid.) that such staffing shortages clearly have an impact on the ability of a service to regularly release nursing, and other staff, for CPD, as well as limiting the range of therapeutic interventions available within such environments (see Chapter Two). The concerns expressed by Beacock (1994) (see Chapter Two) that within forensic nursing education there needs to be a more focused and innovative education strategy does not, by

2002 seem to have been realised. The observations revealed through data collection in this study (see Chapter Four, Results II) concerning nurse respondents, are descriptive only, as opposed to analytical. However the Results are useful in profiling nurses working in secure environments, and contextualising their position within the profession in terms of the need for a focused post-registration development programme. The descriptive observations within this study, in this area, point toward further analytical work in the professional development profile of FMHN's, as well as issues related to recruitment, and ensuring a balance of graduate nurses within the service, along with more traditionally registered staff. Future work in this area might give specific consideration to correlational research between descriptive observations of post-registration qualification of nurses (type and level) and clinical decision making ability.

This study can claim to be one of the early pieces of work, which addresses the clinical decision making skills of Nurse Consultants in the forensic field. The context can be considered to be unique in the sense that Nurse Consultants, at time of writing, will likely have been in post for a maximum of two years. The core of this study analysed inter-rater reliability of Nurse Consultants and nurses with a Benchmark Nurse, using the Cohen's Kappa statistical test determining a measurement of agreement following the generation of categorical data (see Chapter Three). The data was gathered from a design which incorporated what is considered to be a core component of the FMHN knowledge base, risk assessment and managing and intervening with victims of abuse (see Tarbuck 1994, Chaloner 2000, McClelland 2001, Chapter Two). The prevalence of abuse as suffered by those in secure institutions and hospitals was reviewed extensively in Chapter Two of this work, and was found within this study to constitute 41% of the patient sample (n=117) (see Chapter Four, Results I). It was therefore reasonable to anticipate that the majority of nursing staff within this study had worked with patients who had been abused in childhood and/or adolescence. Interestingly a further aspect of this study, revealed that 94.1% of a sample of clinical staff from a range of professions within the same MSU's n=34) had experience of working with patients who had been abused (see Chapter Four, Results III). This descriptive observation, coupled with the nurse respondents reports in the themed rationale analysis (see Chapter four, Results II) is clearly indicative of abuse and childhood maltreatment being encountered

frequently within the clinical practice of nurses, and other clinicians, working in MSU's. The usefulness of this focus of the study was therefore in its unique address of this aspect of FMHN clinical practice, considered to be a core skill of forensic mental health nursing (see Chapter Two). The gaps in FMHN literature appear to revolve around the use of research into the skills base of forensic nursing (Tarbuck 1994, Chapter Two) as well as there being a weak research literature compared to review and practice literature (see Peternelj-Taylor 2000, Chapter Two). Notions of expert practice in nursing are currently focused on the role of the Nurse Consultant in the UK (see Parish 2000, NHS Executive 1999, Cox 2000, Chapter Two). It is for this reason that this study focused on the FMHN respondents, and forensic Nurse Consultants and their strength of agreement concerning severity of maltreatment suffered by patients, against a Benchmark Nurse. There is a paucity of forensic mental health nursing research addressing specific aspects of clinical practice, particularly research which incorporates examination of a newly developed forensic nursing role. It is for this reason that this study looked to the innovative combination of examining relevant clinical phenomena, and the consistency of clinical decision making regarding this phenomena, as well as incorporating the inclusion of a newly developed nursing role, which has at its core concepts of expert practice. The choice of a gold standard or Benchmark Nurse, for Nurse Consultants and nurses to be measured against, was based around such a person having worked as a nurse, in a forensic clinical environment, and having a lengthy clinical experience. Appropriate post-registration qualifications were deemed to be necessary, as well as experience and knowledge of working with patients who had been abused in childhood/adolescence. As opposed to targeting a fellow Nurse Consultant, which would have entailed measurement of like with like, this researcher, following discussion with the supervision team, chose to use himself as the Benchmark Nurse, being able to fulfill all of the requirements listed. Thus the research was able to present a 'real' as opposed to idealized picture of forensic nursing as it is currently practiced. There is a great deal of expectation in the role of the Nurse consultant, expectation which perhaps belies the educational development of forensic mental health nursing over the last few decades (or perhaps the release of nurses for the purpose of educational development). However this work is not just about nursing, or indeed newly created nursing roles, it is more a focus on the actual working environment and practice of clinicians in forensic environments, and the experiences of the patients who are resident in medium secure settings. The work has

closely examined what is often an inadequate approach to documenting the key clinical variable of experienced abuse. That such inadequate documentation, at once brief and often lacking in detail, is used as the main source informing clinicians attitudes, knowledge, and reasoning strategies when rating severity and determining intervention, is perhaps of concern. The value of this clinically focused research is in its recognition of how systems of clinical documentation in health care can sometimes mirror the knowledge base of clinicians. This in tern leads to further questions revolving around the effect of poor clinical record systems on clinical intervention, and of how an inadequate knowledge base can impact upon the way in which clinicians record cretin clinical variables.

In utilising the Cohen's Kappa convention related to strengths of agreement (see Chapter Three, Everitt 1992, Barer 2002 URL) to determine nurse respondents agreement regarding severity of maltreatment in the sample of patients (n=24) (see Appendix Five), the best agreement achieved between the sample (n=34) combining both nurse respondents (n=29) and Nurse Consultants (n=4), was calculated as fair to moderate agreement (see Table 11). Three of the Nurse Consultant sets of variables were valid, and these three were calculated as agreement, which was fair to moderate against the Benchmark nurse. Of the nurse respondents (n=29), ten (34.4%) were recorded as agreement calculated to be fair to moderate, with the Benchmark nurse, whilst thirteen (44.8%) were recorded as agreement calculated as poor (see Table 11). Kappa computation is based on agreement of each level between observers, and seeing how many one would expect randomly. Valid observations were found in twenty-six of the thirty-three comparisons tested. A small number of levels were not present for a number of observers, and a full computation was not possible. The possibility of removing levels for one observer was discussed within the supervision team (associated with this study). However this solution was not thought to be appropriate, as it would likely improve agreement amongst these two observers. Further to this the possibility of another method such as intra-class correlation coefficient was discussed, but as a parametric test this was incompatible within the data, which were not normally distributed. The actual number of instances in which computation was invalid was few, and consequently these comparisons were omitted. There was therefore no agreement, in evidence, which could be considered 'good' or 'perfect' in any of the twenty-four randomly selected cases of maltreatment. The

absence of what might be considered 'good agreement', particularly among the Nurse Consultants and the Benchmark nurse was surprising. The design of the questionnaire (see Appendix Five) had ensured the inclusion of a severity of maltreatment classification referenced in the evidence base associated with this area. This classification system is both comprehensive and clear in detailing distinct levels of severity and categories of maltreatment. Whilst a degree of subjective opinion is expected within such an exercise, similarities of educational and clinical experience between Nurse Consultants and the Benchmark nurse should perhaps have predicted at least one instance of good agreement. Instead there were three (one invalid) instances of fair to moderate agreement (one of the Nurse Consultants measures of agreement being invalid).

The standard of Nurse Consultant agreement (undertaken manually), with each other, extended to only two cases, despite the similarity in both their educational and clinical backgrounds (all educated to masters level, all with 10 years plus experience), their registration qualification (all RMN), and age (all aged 30 years and over). Their Masters level study had variously focused on Psychosocial Interventions, Forensic Behavioural Science, Health Science and Criminology. Interestingly the Benchmark nurse had a similar profile, having studied Clinical Criminology, having registered as an RMN, was aged 30 years plus, with 10 years plus experience. Again in ranking such cases using a clear severity of maltreatment classification, a greater frequency of agreement, (better than agreement levels which are 'fair to moderate') between the Nurse Consultants themselves, is perhaps to be expected.

However there are other considerations, which should be taken into account when examining the inconsistency in agreement. As previously indicated five respondents (2 Nurse Consultants and 3 of the Nurses) on twelve occasions chose not to provide a ranking for a case, indicating that the lack of information provided, concerning the case, prevented an informed decision. Unfortunately there was no more information, which could have been given. The method used in collecting data on maltreatment suffered was based upon recording all information within the case file, based on abusive experiences, which could be found. Therefore there was no more information, than was actually given in the case information (see

Appendix Nine), which could have been provided. In clinical practice however the patient themselves could be approached to clarify issues, or to provide further information, and this is perhaps a limitation of research allied to clinical decision making as a desktop exercise. Many clinicians actually provided a ranking of severity, but within the rationale indicated that they would be appreciative of more information (see Chapter Four, Results II). This would therefore appear to be a recommendation for clinical practice. If this area of clinical work is important in forensic practice, and the literature indicates clearly that it is, then there is clearly a need for clinicians to document, more accurately, information concerning abuse or maltreatment suffered in childhood and/or adolescence. Certainly it is noteworthy that the information secured from the case files was at best brief. This important information was often buried within volumes of case notes, and when discovered often provided no more than a sentence or two detailing what was sometimes the most serious and life threatening abuse suffered in childhood. This researcher found that such information was often omitted from later case summaries.

The forensic practitioner works in what may be considered to be a medico-legal environment. That is to say much of the documentation and recorded information, concerning a patient, could find its way into court proceedings, or affect a return to prison, or affect a sentence a patient may receive at a future date. This may account for the way in which some of the Nurse respondents ranked some of the cases (see Chapter Four, Section 4.6). A number of respondents tended to err on the side of caution regarding their ranking, dependant upon certain words occurring in the text of the case of maltreatment. For instance when respondent 5 ranked case 92 as 'moderately severe', the rationale focused on the observation that the abuse was 'suspected'. Similarly respondents 9 and 27, despite information concerning regular sexual assaults on case 102, ranked the case 'moderately severe'. The rationale provided made comment on the report being a self-report, as opposed to information from an independent source. The clinical decision was therefore given a steer by the detail provided in relation to each case, further evidence of the need to document as accurately as possible.

A small number of respondents chose to make comment on the severity of maltreatment classification (Browne and Herbert 1997, See Appendix Two). This classification is, in the

authors (ibid.) own words 'a tentative attempt to classify incidents', recognising how important it is 'to give some indication of minor, moderate and severe incidents' in clinical practice (ibid. p9). There are of course problems with a severity approach, revolving around determining the severity of psychological or emotional abuse, and of how multiple forms of maltreatment can exist at one time (see Chapter Two, Section 2.13). Despite the occasional non-ranking, and fair to moderate and poor inter-rater reliability, the nurses frequent comments concerning the paucity of specific information and detailed evidence is perhaps indicative of a non-passive role on the part of the nurse respondents. Their withholding of a judgement or ranking, or agreement to rank with caution is important, particularly with respect to their role as forensic mental health nurses. The context in which such nurses function stresses the role of documentation, and this non-passive engagement in the ranking exercise (despite the inconsistency of ranking) is perhaps indicative of such nurses being cautious in making judgments which could have a significant impact on the care and management of patients. This caution is evident even within the context of an anonymised research exercise. At times there also appeared to be a perception among respondents that certain pieces of information were being withheld. There were numerous instances of respondents providing rationale on what they imagined would be a future abusive scenario for the patient in the case study, or likely occurrences of abuse elsewhere in the family. This is clear evidence of the Nurse respondents thinking beyond the classification provided, a creative imagination, which would likely have played a part in the ranking of severity in such instances where inter-rater agreement differed, as opposed to the more straightforward use of case information and the classification scale provided.

For each case (1-24) of maltreatment a rank (1-4) was requested from the FMHN. The respondents were then requested to provide an indication of how their experience had prepared them to make a competent judgment in the respective case, ranging between 'a very large extent' through to 'no extent'. The rounded means for each case of maltreatment and the corresponding competency judgement can be seen in Table 13. Interestingly this self-rating of competency, in making a judgment of severity was almost 100% confirming of nurse respondents again being cautious in their choice. In every case, save Case 23, nurses on average indicated that they thought themselves able to make a competent judgment 'neither to

a very large, nor to no extent'. This latter finding contrasts somewhat with the high prevalence of abuse experienced by patients in such settings, and the respondents rationale indicating their frequent contact with patients who have been maltreated in childhood and/or adolescence. Therefore the nurses tend to exercise caution in terms of their own clinical ability in making a judgment of severity of maltreatment, despite their extensive clinical experience in the sample area of practice. Alexander (1989) in discussing the work of Patricia Benner and her work 'From Novice to Expert' would perhaps recognise this group of staff as vacillating between the advanced beginner and the proficient nurse. These concepts of nursing incorporate, and demonstrate, acceptable performance, an ability to prioritise, and an intuitive grasp of a situation based upon background and understanding. Alexander (ibid. p 190-191) indicates how such nurses will have coped with a range of situations as an advanced beginner, and as a proficient nurse can grasp a situation as a whole. However the leap into expert practice requires the nurse to go beyond analytic principles of rule, guideline, maxim, and take their intuitive grasp of situations to enable a focus on accurate regions of a problem, without wasting time on alternative diagnoses and solutions (see Alexander p191). This apparent mismatch of clinical experience and low self-confidence in self-rating competency levels, perhaps suggests that clinical experience requires support from education research and evidence based knowledge and practice. Interestingly amongst the four Nurse Consultants, only one indicated that their experience had prepared them to make a competent judgment to a large extent. Even this Nurse Consultant respondent (Respondent 4) moved between self-ratings of 'large extent' and 'neither very large nor no extent' in terms of self-rating of competence to judge severity. Another Nurse Consultant rated her ability to rank competently as 'no extent' throughout. The remaining two ranged between the middle three ratings. If victimisation and maltreatment in childhood were not such key issues in forensic practice, as evidenced within the literature and clinical practice, and forensic educational curricula, then this latter finding would be less of a concern. However it is apparent that this is an area where nurses are exercising caution, which may be as a consequence of a lack of preparation or education. Similarly there would appear to be marked inconsistency in inter-rater reliability regarding clinical judgment in this area. Coupled with the low uptake of CPD, and the low number of staff engaging in CPD which can be considered 'beyond basic' this would appear to be creating a recipe for continued stasis in clinical development.

This focus of this study (see Chapter Four, Results II) has addressed one specific area of forensic nursing practice, but one which is considered to be key to advanced practice amongst FMHN's, and amongst other professional groups employed in forensic environments. There are contextual problems associated with implementing such research findings, particularly the apparent problems revealed with this study, and within literature (see Chapter Two) in terms of uptake of CPD in forensic environments. The inconsistency in agreement concerning severity of maltreatment suffered by in-patients combined with the caution exercised in self-assessments of competency in making such judgments may reflect the mediocre uptake of post-registration education. Similarly the low level of uptake beyond that which is considered basic may also account for the inconsistency of agreement and caution in self rating of competence in decision making (see Chapter Four, Results II). Nurse Consultants are specifically recruited on the basis of Masters level education in the appropriate field, as well as on the ability to combine expert practice, research evaluation skills, and service development skills (see NHS Executive 1999, Chapter Two). The purpose of this aspect of the study was not to denigrate the expert practice of Nurse Consultants, but to examine consistency and inconsistency in agreement in an area of clinical practice, considered to be a core component of FMHN skill. Nurse Consultant's agreement with a Benchmark nurse, within this study, was revealed as fair to moderate and clinical agreement was also revealed as inconsistent amongst themselves. Elements of subjectivity, whilst understandable, should be minimised when using a classification system, as in this study. Improved agreement is required in the area of severity of maltreatment suffered by individuals, if only to tailor specific services and interventions to certain groups of patients. Mullen's (1993) work in particular (see Chapter Two) has found that the more intrusive and severe the childhood abuse, the stronger the association to adult psychopathology.

This study has illustrated inconsistency in agreement over levels of severity, among both nursing staff in environments where there is high prevalence of childhood abuse, as well as amongst expert nurse practitioners that are also employed in such environments. The foundations of future work in this area have therefore been illustrated within this study. Browne and Herbert's (1997) work related to the severity of maltreatment classification (see Appendix Two) was an attempt to assist the clinician in classifying incidents of

maltreatment/abuse. However the authors themselves (ibid. p9) recognise how co-existence of some or all, forms of maltreatment, which differ in frequency direction and force, can effect the classification process. The themed analysis of the rationale provided by nurse respondents (see Chapter Four, Results II) indicates that this latter observation may have contributed to some of the inconsistency revealed in agreement levels. This study has been groundbreaking to an extent in revealing this finding concerning the reliability of a classification system used by a clinical group, in that one of the purposes of designing the questionnaire in this way was to determine the usefulness of such a classification system in rating severity of maltreatment (see Appendix Five for questionnaire).

The findings from the use of Cohen's Kappa statistical computation is indicative of agreement of severity classification being better than by chance. The agreement is not perhaps what would have been expected, particularly between Nurse Consultants and the Benchmark nurse. Despite this 'better than by chance' observation however there does appear to be a shortfall in consistent clinical decision making in this area, combined with a cautious approach to self rating of competence to judge phenomena associated with severity of maltreatment. A more systematic way of ensuring the inclusion of study, in this area, in FMHN curricula should be undertaken. A more defined and focused strategic approach to FMHN pre and post-registration study is required (see Chapter Two). Kettles and Robinson (2000 p 276) write of the future development of forensic nursing as emerging from a reactive past into a proactive new millennium. Unfortunately much of forensic practice service development has been reactive as opposed to proactive (see Chapter Two) and this reactivity has been a feature of its development over the last two centuries. Kettles and Robinson (2000 p 277) discuss forensic nurse education as particularly problematic, with little at pre-registration, and only just developing at post-qualification. The authors (ibid.) argue that more specialised and advanced skills and competencies are the way in which new professional recognition can be forged in FMHN practice. The key message from the focus area of this study related to nurse respondents, is that in combining clinical practice elements of importance, and qualitative and quantitative data collection, a research project can identify inconsistency in clinical agreement among nurses, highlight certain observations related to gaps in education and the knowledge and evidence base, as well as confidence in clinical practice amongst FMHN's. If, as Kettles

and Robinson (2000) suggest, that forensic nurses are functioning within an advanced practitioner role, rather than within specialism in its own right, there may, in the future, be scope for development of specific registration for nursing mentally disordered offenders. If this were to occur then this study has indicated the specific role in such curricula for study related to victimology, abuse/maltreatment issues and increasing the competency level of nursing staff involved in this area of practice. This focus would enable a greater frequency of examination of clinical variables in forensic mental health nursing research. As illustrated in Chapter Two FMHN research has a tendency to be bogged down in defining what the FMHN is, and is not. The address of clinical variables within revised FMHN curricula, and research, in a more focused way, reflecting the literature and addressing serial measurements of behaviour as opposed to the easily measurable (see Chapter Two) would perhaps contribute to developing FMHN's to be more consistent and confident in clinical practice.

5.2 Patient Data (Results I)

The patient data recorded within this study (see Chapter Four, Table 6) formed the basis of the focused aspect of the study, previously discussed in this Chapter. The rationale for the collection of demographic data on the patient sample (n=117) is related to one of the aims of the research (see Chapter One) concerning the determination of prevalence of abuse in a medium secure unit population. The study also wished to examine association between such demographic variables, and ensured a review of the literature, which had similarly examined a wide range of associations of similar variables, in a range of settings (see Chapter Two).

Medium and other secure clinical environments are perhaps not as well researched as non-secure environments due to problems of access. In terms of confidentiality, and the extremely sensitive nature of some of the patients case files this restricted access is perhaps legitimate. However research into such clinical areas can be affected (see Spatz-Widom 1989b, Chapter Two) with the consequent generation of hearsay and commonly held beliefs that large numbers of patients and prisoners in institutions have been victims of abuse or neglect (see Weeks and Widom 1998, Chapter Two). The ethical approval to conduct this study in three

medium secure units was lengthy, resulting in a more complex submission, and a multi staged series of establishing contacts, than would normally be undertaken in another hospital or clinical environment. Coupled with the fact that many MSU's were formerly regional secure units, with wide areas of catchment over different parts of the country, the time spent organising travel and liaison with staff, who were not directly involved in the study, was somewhat extended. The physical environment is also restrictive. The MSU is a functioning working environment, quite rightly geared toward patient care, treatment and assessment, and not specifically designed to facilitate research. Those conducting research involving patient case file information cannot always secure all information from medical records departments, particularly when specific clinical information such as records of maltreatment suffered as a child form the basis of the study. Consequently access to the wards is required, necessitating escorted movement from one area to another, as a consequence of the majority of wards being locked in such units. As discussed briefly within Chapter Three, case notes were often being used in clinical case reviews or team meetings, necessitating meticulous records being maintained as to case files which had been missed, so as to enable return to certain wards at a later time. The clinical notes between MSU's (and indeed between wards in the same MSU) are far from uniform. One of the three MSU's within this study had attempted a uniform approach to the maintenance of clinical notes, however there was wide variation in how they were maintained in two of the three units studied. This lack of uniformity had a direct impact on the consistency of records regarding basic information such as age, marital status and diagnosis for example. The nature of such environments usually entails frequents admissions, and on some occasions a recent admission record of demographic information (such as recorded in this study, (see Table 6) had not been recorded. Consequently much time was spent finding records of basic information, which ordinarily could have been expected to be found on the patient case file fact sheet. Summaries of key clinical information, whilst frequent and routine in some areas, were not so in others. Hence there were sometimes very lengthy periods spent reading many volumes of clinical notes to find out about instances of maltreatment or abuse, which may have occurred in childhood and/or adolescence. This researcher however, having had clinical experience of such environments anticipated many of these areas, which may have proved to be serious hindrances to other researchers. Previous to this study this researcher had conducted a similar study in a number of different medium

secure environments, providing useful experience for this study. The three ethical committees had stipulated the condition of establishing a research contact, this stipulation was actually a very welcome and useful aspect of data collection whilst this researcher was in each unit. It is clear then that many problems can be encountered in accessing patient data in such units. A time schedule is always necessary in conducting a large research undertaking, however it is clear that in researching secure clinical environments in particular, more time than is usual needs to be afforded the data collection process. A significant degree of discretion is also required in that the data is often collected in the ward area, albeit in quiet rooms and staff bases. The presence of strange faces on the wards can be provocative to some patients, particularly those who may be in a disturbed or confused state, and any researcher should be understanding of such circumstances in secure environments.

There is a danger, in collecting such data, of interpreter or researcher bias, particularly in extracting from the case notes information concerning a violent index offence, or a case of childhood/adolescent abuse. The nature of what constitutes each, has in Chapter Two of this work, been highlighted as difficult. Corby (1993) (see Chapter Two,) has illustrated the difficulty associated with using an official (usually governmental) definition of abuse, as well as a definition devised for the purpose of a research study. In utilising an age threshold of eighteen (see DOH 1999c) this study recognised that many would object to this age as too old, particularly considering the legal age of consent, but perhaps acknowledging the grey area between ages 16 to 18 where non-consensual activity can still occur within the family, and this age group still being considered vulnerable in many respects. However the operational definition chosen for this study (see DoH 1999c, Chapter Two, Section 2.5) concerning childhood and adolescent abuse is comprehensive. This latter definition is notably more inclusive than exclusive, and is useful for clinical practice in giving consideration to the importance of the impact of any abuse, as well as recognising both contact and non-contact abuse (see Chapter Two, Section 2.5). This definition is also useful, in mirroring almost, the severity of maltreatment classification utilised in this study (see Appendix Two). Thus a degree of consistency is achieved within the study. Despite such measures however estimates of prevalence rates, particularly when definitions of abuse are inclusive as opposed to exclusive, are variable, Vogeltan (1999) (see Chapter Two, Section 2.6) illustrating how

inclusive definitions of abuse give higher estimates of prevalence of abuse than those which are exclusive. Further criticism of prevalence studies and findings in clinical settings can be found in the work of Spatz Widom (1989b) commenting on small numbers of violent or homicidal offenders, poor case histories and reliance upon retrospective reports (see Chapter Two, Section 2.6). This study recognised the problems associated with its retrospective design, specifically in including evidence of maltreatment from the case notes, which was in the form of self-report. Many of the nurse respondents made comment on this matter, when asked to provide a rating of severity of maltreatment (see Chapter Four, Results II). Weeks and Widom (1998) have, as discussed earlier, been critical of uniformity, in terms of measurement techniques in determining prevalence. It is largely because of this critique that this study was drawn toward an official operational definition used within a credible survey by a credible organisation. The National Society for the Prevention of Cruelty to Children have used the official DoH (1999c) definition, in their national production of child abuse figures and this study endeavoured to utilise the same level of uniformity within the clinical domain. The use of such an operational definition also served the purpose of minimising researcher bias. Similarly the use of Archer and Browne's (1989) definition of violence reflects a broad definition, which contextualises violence to both injury and the restriction of freedom. This definition, combined with Browne and Herbert's (1997) two way classification of violence concerning both active abuse and passive neglect, provided a useful foil to potential accusations of researcher bias in determining what was, and was not, a violent index offence (see Chapter Two, Section 2.5).

Having reviewed the literature, particularly the more recent surveys of secure hospital environments (DoH 2000/2001) the findings of this study illustrated in the descriptive data in Chapter Four, Results 1 Table 6 comes as no surprise. The large proportion of males to females in the sample (n=117), (77.8% compared to 22.2%), as well as the ICD-10 diagnosis of Schizophrenia, Schizotypal and delusional disorders, F20-29 (WHO 1992) constituting 81.2% of the sample, was an expected finding. Similarly the fact that 59.8% of the sample were detained under the 1983 Mental Health Act on a guardianship with restriction order (37/41) was equally unsurprising. Ethnicity of this sample (70.1% Caucasian and 14.5% African Caribbean) as well as marital status (77.8% single, 10.3% married) were demographic

descriptive observations very much in line with the department of health review of medium secure units (DoH 2000/2001) (see Chapter Two, Section 2.4). This latter review collated data on the entire population of those resident in MSU's in England and Wales, a population of 1341 patients.

As well as findings in this study related to mean age (37.8 in this study), and further breakdown of mean age by variables of gender, index offence, abuse/neglect suffered and diagnosis (se Chapter Four, Table 7), the range of demographic observations of the sample (n=117) concurs with published surveys related to the same and similar populations. Taylor (1998) for example recorded the mean age of men as 39 years, and women as 37 years in a special hospital population, and very similar figures for the MSU population of England and Wales can be found in the most recent survey (DoH 2000/2001) (see Chapter Two, Section 2.4)

A series of Chi-Square tests were conducted examining association between variables recorded in the descriptive observations (see Chapter Four, Table 8). The Chi-Square analysis revealed no association between the range of variables tested (see Chapter Four, Table 8), except for an association between gender and abuse neglect suffered in the sample (n=117). Forty-eight (41%) of the sample (n=117) had been found to have been abused in childhood and adolescence, and of this number twenty-nine patients were male and nineteen patients female (see Table 6, Chapter Four). The observations for gender split in the sample overall (n=117) included ninety-one (77.8%) males and twenty-six (22.2%) females. The variables of gender and abuse/neglect suffered in childhood and adolescence in this sample were therefore not independent of each other – that is – they were related. This finding within a sample taken from medium secure psychiatric hospitals is interesting in light of certain literature related to findings on female samples who have been abused. Brierè and Runtz (1988b) (see Chapter Two) for instance found that females who had been abused, and presenting at a crisis counselling centre were more likely than non abused females to be taking psychoactive medications and have histories of substance misuse, as well as having made one suicide attempt and being more self destructive and expressive of anger. Doyle-Peters (1988) similarly addressed contact abuse among females prior to the age of eighteen years, and the

higher likeliness of psychological difficulty in adulthood than those females with no or non contact abuse (see Chapter Two, Section 2.7). The finding in this study related to an association between gender and having been abused in childhood and adolescence is very useful insofar as it supports a specific focus of inquiry and intervention, particularly in the womens services which have been recently developed, and are under development in secure psychiatric hospital services in the UK (see Chapter Two, Section 2.4, DoH 2000/2001). Such information also supports the inclusion of assessment and intervention schedules related to abuse/maltreatment as experienced by female patients into appropriate forensic practice based educational curricula.

One of the interests of this study had been the association of childhood abuse and neglect and the links, or association, with violent offending. However, as has been observed within the literature (see Glasser et al 2001, Chapter Two) one of the problems associated with examining variables such as violent offending in forensic psychiatric settings is that residents are a high risk group for violence already. The violence in the histories of patients within secure settings can occur either from experience, as victims of abuse, or be exacted upon others, as perpetrators. The rationale for admission to a MSU usually involves a degree of unmanageable behaviour in other less secure settings. It is very likely that hypothesis tests analysing proportion would be biased, and inappropriate for an environment where one variable, such as having a violent index offence constitutes a high proportion of the population, 94% of the sample in this study, (see Chapter Four, Table 6). It is for this reason that an examination of probability was undertaken (see Chapter Four, Table 9). As can be seen from Table 9 one of the observations, that of having been abused and not having a violent index offence, was less than five, thus invalidating the use of a Chi-Square test of association. Therefore the joint probabilities associated with abuse having been suffered in childhood/adolescence, or not, and a violent index offence having been committed or not was calculated. The data collection was able to determine that the sample (n=117) fell into a number of categories where percentile observations could be calculated, abused with a violent index offence (40.2%), non-abused with a violent index offence (53%), abused with a non-violent index offence was very low (0.09%), and non abused with a non-violent index offence (5.1%) (see Chapter Four, Table 9). Therefore this probability determination of expectation

was able to illustrate the percentages of the joint probabilities, or the probability of the joint probabilities. There are no clear statistics in the medium secure unit population overall (1341 patients, see Chapter Two, DoH 2000/2001) to indicate the number who have been abused in childhood/adolescence and who may have committed a violent index offence, or who have not been abused and have committed a violent offence and so on. However the opportunity of sampling the population within MSU's (albeit 117 patients) enables the reflection of this sample into the population. The joint probability calculation reveals probabilities such as a chance that 40.2% of a medium secure unit population who have committed a violent index offence will have been abused in childhood and adolescence, whereas the chance for having a violent index offence and not having been abused is 53.8%. The lowest probability is that for having a non-violent index offence and having been abused in childhood/adolescence. In this latter respect, and in selecting one person at random from the whole MSU population, based on the sample (n=117) there is a 0.09% chance, or nine in one thousand chance that an individual will have been abused and have a non-violent index offence. This a priori (first principles) approach to concepts of probability is innovative insofar as it utilises data on a phenomena of concern in forensic practice, which is not routinely addressed within the research. In terms of developing services within forensic psychiatric institutions probability data can contribute extensively to specific needs analysis. Gaps within the research are thus addressed in the innovative address of clinical phenomena in forensic practice (see Chapter Two), at a time when specific needs analysis are examining the development of new services and interventions in forensic practice (see DoH 2000/2001, Chapter Two).

5.3 Results III: Knowledge Base and Opinions Regarding Clinical Phenomena

The questionnaire (see Appendix Six) devised to secure data concerning a range of clinicians' knowledge base and opinion, concerning concepts of childhood abuse, mental disorder and violence, was a further approach to examining these concepts within a medium secure psychiatric setting. The response rate of 37.7% was somewhat disappointing. However it is worth recognising that clinicians, particularly in challenging areas such as forensic practice are surveyed frequently. The response rate compared to the other questionnaires used within this study (see Chapter Four, Results II) was lower however. Clinicians very often respond to a

clinical rating system, as used in the maltreatment questionnaire (see Appendix Five) more favourably than a questionnaire which might be perceived as threatening, particularly those which focus on knowledge on particular topics. As Parahoo (1997 p278) illustrates, knowledge questions can be threatening to health professionals as the data may fall into the hands of employers. However attempts were made to ensure a good response rate, ensuring both anonymity and confidentiality, combining closed ended questions, as well as the scope for involvement by providing the opportunity for clinicians to provide a rationale for their agreement or non-agreement, as well as limiting items to fifteen statements (see Polit and Hungler 1995 p281). The questionnaire was also designed in such a way as to avoid extreme statements, and further to this utilised a Likert scaling technique, which is known to be popular amongst health professionals (ibid. p281). However, whilst ensuring that a sufficient amount of time had elapsed between completion of the other questionnaire in this study (see Appendix Five) and the knowledge and opinion questionnaire there still may have been reluctance on the part of some to respond to both surveys. Some of the nurses may have completed the questionnaire, related to rating severity of maltreatment, and may have been the same nurses asked to complete a second questionnaire. Whilst the research contacts avoided this situation amongst nursing staff, interested parties who were targeted, may have chosen not to return questionnaires. This does not account for other professional groups not responding however. Many consider some self-report questionnaires to be superficial, particularly in the use of closed ended questions, open ended questions being viewed as providing the ability to answer in a more rich and fuller way (see Polit and Hungler 1995 p276), and this may possibly account for the response.

The use of questionnaire is advantageous in some ways however, particularly in their ability to secure additional information. As with the maltreatment questionnaire previously discussed in this chapter (see Appendix Five), descriptive observations for the knowledge and opinions questionnaire (see Appendix Six) revealed a relatively experienced group of staff among respondents, the mean years of service for those in the sample of respondents (n=34) being 12.59 years (see Chapter Four, Results III). The majority of respondents were nurses who numbered fourteen (41.2%) and Psychiatrists who numbered ten (29.4%). The rest of the respondent group included three social workers (8.8%), five occupational therapists (14.7%)

and two Psychologists (5.9%). The lesser number of these latter three professional groups also reflects perhaps the smaller number of such professionals in MSU's. As with the nurse respondents in the maltreatment rating study (Chapter Four, Results II) a high proportion of the respondents indicated that they had worked with patients who had been abused (94.1% v 5.9%). There would perhaps be a reasonable expectation therefore of a degree of knowledge in the area of maltreatment and abuse, considering the frequency with which all professional groups encounter such patients. This study also had a small interest in the amount of respondents who had been involved in a violent incident within the previous twelve months. West and Abolins (2001) have written about the mandatory preparation many staff members receive in MSU's in dealing with and managing violence and aggression, and there was an expectation that many staff if involved in violence frequently would perhaps be informed to a large extent of issues related to violence and violent behaviour. However only thirteen staff (38.2%) indicated that they had been involved in a violent incident in the previous twelve months, twenty-one (61.8%) had had no involvement in a violent incident during the same time. This of course may well be a spurious assumption, involvement in a violent incident does not necessarily equate to knowledge of violence. However as a guide to the profile of the respondents it was of interest to this study insofar as it indicated a picture of the working practice of this varied staff group. Descriptive observations of the sample (n=34) indicate an experienced staff group, comprising equal numbers of males and females, the high majority of them having worked with patients who have been abused in a variety of ways, and just over one third having had direct involvement in violent incidents in the previous year.

Statements included in the questionnaire (see Appendix Six) reflected the literature and knowledge base in the areas associated with child abuse and studies examining mental disorder and violence (see Chapter Three). Some were deliberately provocative, but not extreme, as illustrated by statement 6, which read as follows:

'children are best brought up in their own families'

There is literature examining concepts of significant harm within the family, providing methods of assessment, clinicians being requested to specifically examine severity and impact

of abuse experienced by a child, and the literature also relates the NSPCC figures concentrating upon rates of harm and death experienced by children at their parent's hands (see DoH 1999c, Browne 1993, Chapter Two). The provocation in the statement was therefore intended to elicit a considered answer from respondents, and further determine evidence of an informed response in the rationale provided. Some of the statements however were more of a grand tour type question, a device used in unstructured interviews, usually a broad question related to the topic under discussion, one, which eases the respondent into the interview (see Polit and Hungler 1995 p272). Hence statement one, which reads as follows:

> 'Adults who recognise and reject abuse suffered in their own childhood are more likely to break patterns of abuse behaviour in which they are involved.'

The statement simultaneously provokes thought in the respondent, but is not extreme or overly challenging, easing them into the rest of the questionnaire.

A series of rounded means were calculated for respondents agreements regarding statements 1-15 in the questionnaire, and the Results can be seen in Chapter Four, Results III, Table 15). These mean levels of agreement were calculated so as to identify broad levels of agreement across a range of professionals surveyed. Seven of the fifteen statements in this calculation received a mean level of agreement of three, which equates to the response neither agree, nor disagree. There are no extremes recorded in the mean levels of agreement i.e. strongly agree (1 or 5) or strongly disagree (1 or 5). These numbers of rounded means of agreement indicate frequent choice of the response 'neither agree nor disagree' and is perhaps indicative of a level of response bias. The caution exercised by many of the nurse respondents in the maltreatment questionnaire used within this study, (see Appendix Five) discussed earlier may also be in evidence among the professional group respondents also. There may be a tendency to sit on the fence, in the absence of knowledge of the research or evidence base related to the topic, and provide cautious responses. Polit and Hungler (1995 p290) refer to this response bias as the social desirability response, or providing answers that are congruent with prevailing social mores. The selection of middle range alternatives may be distorting findings, and not be representative of the knowledge base or opinion of the sample (n=34) of professionals working in the three MSU's. A further quantitative analysis of the data

generated by the questionnaire concerning knowledge base and opinion amongst professionals was undertaken. A one-way analysis of variance (ANOVA) was calculated utilising the statistical package SPSS 10 , for mean levels of agreement by profession. The ANOVA tests supported the null hypothesis, that there was no difference in the mean levels of agreement when factored by the variable profession (see Chapter Four, Results III). The one-way ANOVA was chosen because of the presence of three or more levels, the analysis contrasting means by examining the source of variation in the data (see Grimm 1993 p258).

However the study incorporated a further form of analysis of the questionnaires related to knowledge base and opinions concerning concepts of abuse, mental disorder and violence, which illustrated a different view of agreement amongst professional groups. As with the severity of maltreatment rating questionnaire discussed earlier in this chapter a themed qualitative analysis of the agreements/non-agreements and rationale provided by the professional groups in the sample (n=34) was undertaken (see Chapter Four, Results III, Section 4:2). This form of analysis enabled closer scrutiny of the responses from specific professional groups, as well as an address of key themes of focus and positive and negative observations (see Table 14). The strength of this alternative approach lay in the rich detail revealed in various responses to certain statements. Statement 5 for instance read as follows:

> 'Schizophrenics are more likely to commit violent offences than other disordered groups'

In reading the responses to this statement, and others, it is worth reminding ourselves of both the context and the parameters of this study and the respondent profile. We know from a series of descriptive observations (see Chapter Four, Results I, II and III) that the MSU environment is one where 81.2% of patients are diagnosed with schizophrenia, have been admitted for reasons predominantly associated with violent offences, and assessment associated with such behaviour (94% violent index offences), and are almost all restricted under sections of the Mental Health Act 1983, as well as almost half of the population having been abused in childhood and adolescence (41%) (percentile observations from the sample n=117). The nursing staff group involved in this study are experienced, and indicate that they

have frequent contact with those who have been abused. Similarly the professional groups surveyed within this study are also experienced, 94.1% of this latter sample (n=34) indicating that they have worked with patients who have been abused. Statement 5 specifically focuses the respondent on a comparison of those with schizophrenia to other mentally disordered groups. The literature whilst acknowledging the caution to be exercised in looking to schizophrenia as causal of violence (Prins 1995, Mustill 1999, Blackburn 1995) has consistently linked schizophrenia to an increased likeliness of offending and violence (Hafner and Boker 1973, Taylor 1986, Lindqvist and Allebeck 1990, Link and Stueve 1994, Reed 1997) (see Chapter Two, Section 2.9). The specific themed analysis of respondents (see Chapter Four, Section 4.9) indicates that Psychiatrists in the study (n=10) generally agreed with the statement indicating that they knew the research to be supportive of schizophrenia being associated with violent behaviour as compared to other disordered groups, particularly when schizophrenia is in its active stage. This agreement among Psychiatrists was not unanimous however, and some of the Psychiatrists indicated that they felt personality-disordered individuals to be more likely to behave in a violent manner. This latter comment by Psychiatrists is also supported within the literature (Chapter Two, Section 2.11) notably by Hare and hart (1993), Serin (1991) and Wallace et al (1998). The nurse respondents (n=14) however gave a more mixed response to statement 5 slightly more disagreeing with the statement than agreed, looking instead to a greater risk of self-harm among schizophrenics than other groups. Disagreement however, was in some instances related to comparing those with schizophrenia to the general public, as opposed to other disordered groups. The occupational Therapist respondents (n=5) were divided between not agreeing with statement 5, and neither agreeing nor disagreeing with the statement. One respondent replied that she did not know enough about schizophrenia to agree or disagree with the statement. Such responses are perhaps surprising considering the focus of assessment in such environments, and the fact that 81.2% of the patients within the MSU's in this study had a diagnosis of schizophrenia. One of the two Social Worker respondents, who provided a rationale for his response to statement 5, disagreed with the statement indicating that he thought there to be a strong media bias, believing the majority of those with schizophrenia not being violent to others. This is perhaps true, but is a response to another statement perhaps such as; 'the

majority of those with schizophrenia are violent'. The Psychologists (n=2) agreed and disagreed with the statement.

The agreeing Psychologist interestingly wrote:

> 'Evidence is = less incidence, but when they do its often severe and against close relatives'

Again this may be true, but seems to be a response to another statement. The Psychologist records agreement, but indicates that he believes there to be 'less incidence', which is perhaps more suggestive of disagreement with the statement. In calculating the mean response for statement 5 across all respondents, a mean of four (or disagree) emerged (see Appendix 15).

These are interesting responses considering the environment, and high proportions of patients resident in MSU's with a diagnosis of schizophrenia. There almost appears to be a response set which, in attempting to de-stigmatise schizophrenia, responds in what may be termed a correspondingly socially desirable way. Whilst one does not expect everyone working within a secure hospital environment to be familiar with the literature and research, one could perhaps anticipate that general awareness of the literature and evidence base in areas such as schizophrenia would be better known in such an environment.

Statement 11 read as follows:

> 'Mental disorder/distress is no more prevalent in adults who have been abused in childhood/adolescence than in adults who have not been abused.'

Whilst there is a certain complexity to some of the evidence base related to statement 11, particularly associated with a range of mediating effects of developmental arrest, situation and environment as well as severity of abuse suffered (see Chapter Two, Section 2.13), there is an evidence base supporting association between childhood abuse and later psychopathology (Mullen et al 1993, Millar and Lisak 1999, Blumenthal and Lavender 2000, see Chapter Two). The Psychiatrists (n=10) almost unanimously disagreed with statement 11, citing clinical experience, and the high numbers of their patients who have been abused. One

respondent specifically focused on the greater frequency of borderline personality disorder and post-traumatic stress disorder as more frequently associated with those who have been abused. The nurses (n=14) also tended to disagree with statement 11, suggesting that residual feelings of guilt, reflection and shame may remain into adulthood. Two of the five Occupational Therapists (n=5) disagreed with the statement, two agreed with the statement. Those in agreement cautiously suggested a range of other causal factors being associated with mental illness. The Social Workers neither agreed nor disagreed with the statement, however one provided a rationale of having a lot of clients who had been maltreated. Both Psychologists (n=2) disagreed with the statement, one suggesting that he felt the statement to be incorrect, but was unaware of the research. The mean calculation for this answer was three (see Table 15, Chapter Four), corresponding to 'neither agree nor disagree'. It is therefore clear, that in some instances, the combination of analytical methods can reveal different results, or results, which are qualitatively different perhaps. The qualitative themed analysis of respondents revealed different, opinions amongst respondents, regardless of the overall mean, endorsing the use of a mixed methodology.

The themed analysis of the knowledge and opinions questionnaire overall was able to identify key themes of focus drawn from additional rationale provided by the respondent sample (n=34) (see Chapter Four, Results III, Section 4.9). The sample overall indicated a belief in childhood and adolescent abuse being common in forensic populations, as well as a strong belief in what may be termed a 'cycle of violence'. This can be seen in the almost unanimous agreement to statement 15:

> 'Many patients exhibit violence as a continuum of behaviour they themselves have experienced.'

This belief in a cycle of violence, coupled with a belief that clinicians can play a part in intervening to prevent recurrence of child rearing patterns (see Statement 12, Appendix Six) mirrors many of the comments made by nurse respondents in the rationale to their ratings of severity of maltreatment experienced by patients (see Chapter Four, Results II). The findings that 41% of patients in the sample (n=117) (see Chapter Four, Results I), had been abused in childhood/adolescence, coupled with the frequency of encountering abused clients, which was

reported by respondents in both questionnaires affords this study a degree of triangulation. The use of multiple methods in this study has been innovative in both collecting and interpreting a range of data concerning the prevalence, both perceived and actual, of abuse and maltreatment in childhood/adolescence. Further themed qualitative analysis (detailed in Chapter Four, Results III, Table 14) derived a series of positive and negative observations from the professional groups responses to the knowledge and opinion questionnaire (see Appendix Six). Again this analysis reveals there to be a wealth of clinical experience evident amongst the range of staff groups surveyed, regarding those patients who had been abused. However this clinical experience appeared to be offset somewhat by the little that was known of the evidence base or research, in the area of childhood abuse and neglect. Similarly, despite a wide-ranging clinical experience many respondents recognised the difficulty encountered in attempting to research this area, not in terms of methodological difficulty, but more in terms of the taboo and sensitivity associated with such work. The strength of these findings is how closely they relate to the gaps in the literature. Considering that abuse and maltreatment, as experienced by MSU patients, is such a frequently encountered phenomenon there does not appear to be a great deal of literature in this area. Similarly, as previously discussed in this chapter, despite calls for the routine inclusion of victimology and research on abuse and maltreatment in forensic educational curricula (see Chapter Two) it is not addressed in such curricula to any widespread extent. The usefulness of this study therefore has been to confirm the presence of the phenomenon, as well as to establish the further need to enhance and develop the confidence and knowledge base of nurses and other clinicians working with mentally disordered offenders who may have experienced abuse or maltreatment during childhood/adolescence.

The homogeneity analysis (HOMALS) undertaken regarding the knowledge and opinions questionnaire completed by a range of professionals is illustrated in Chapter Four (Results III Diagram 2). This analysis of association (Homals) is indicative of the high proportion of male Psychiatrists working within MSU's, as well as the unsurprising observation that Occupational Therapists are less likely to have worked with those who have been abused, or have been involved in a violent incident in the previous twelve months (this primarily being linked to level of contact with patients). The spatial distance of Psychologists, from the variables of

having worked with those abused, and having been involved in violent incidents is both surprising and unsurprising. Unsurprising in that both nurses and psychiatrists have very frequent contact with all patients, this perhaps explaining their apparent close association with abuse work and being involved in violent incidents as opposed to Psychologists and Occupational therapists. However this does not fully explain the distant spatial gap between Psychologists as a profession and having worked with abused patients. The small number (n=2) of Psychologists in this study may account for this observation, a large number of Psychologists may subsequently reduce the spatial distance between working with abused clients and profession. Interestingly the Social Workers have a close association with both having worked with abused clients and having been involved in violent incidents. This analytical approach to association is innovative in the sense of supporting a range of findings revealed within other areas of this study.

Certain aspects of the results of this work, notably the inconsistency apparent in determining severity of maltreatment suffered (see Chapter Four, Results II), the gaps in clinicians knowledge base concerning concepts of childhood abuse and neglect (see Chapter Four, Results II and III), and the high proportion of those patients abused in MSU's (Chapter Four, Results I) suggests an area of clinical concern in secure environments which could be addressed more systematically and strategically. The sample (n=34) used in this study, who were subject to Homals was perhaps too small to be sufficiently representative, however Homals utilised in a survey of a greater number of staff could examine gaps, and close areas of association, between relevant variables. Such analysis could then result in a refocused target of specific staff groups regarding appropriate education and training, as discussed earlier within this chapter.

The strength of this work has been the identification of a mismatch between clinical experience of working with abused and maltreated individuals, amongst a range of clinicians working in MSU's, and the knowledge of the research or evidence base associated with this area. Some clinicians consistently exercise caution in rating their clinical decisions (see Chapter Four, Results II), and are inconsistent in their use of the evidence or research base (see Chapter Four, Results III). This contrasts somewhat with a staff group who clearly have

a wide experience of working with abused patients, in an environment where there is a high prevalence of abuse having occurred (see Table 6). This situation is combined with a high probability of a continuum of violence amongst patients who have been abused in childhood/adolescence and have an index offence, which is violent. Future developments in forensic practice are again being heralded as contributing to the practice and scope of professionals working in such areas. Developments associated with nursing career frameworks, in the form of nursing consultancy, as well as the developments associated with women's services, and services for those deemed to have a dangerous and severe personality disorder are examples of three changing agendas in forensic practice. This study has illustrated a multi-method approach to studying clinical phenomena in MSU's, as well as an examination of clinicians' knowledge base and inter-rater reliability linked to this phenomenon. The extension of this work in line with such developments is clear. Nurse Consultants as expert practitioners are intended to forge specific service and practice developments, not least nurse led services, and advanced practice within their specialty. Evaluation of consistency in clinical decision-making amongst this group is therefore important to the nursing profession, and to improved health care generally. The opportunity afforded to forensic practice in the funding of new service developments, and the increased focus on practice in this area should be embraced. Strategic approaches, and proactive approaches to education and service development, as opposed to the reactive measures of the past, need to be developed, and nurtured through studies such as this.

Chapter Six: Conclusion and Recommendations

6.0: Introduction

This chapter will both reflect upon the research questions and the hypotheses posed in chapter One, and make recommendations related to the utilisation of findings from this research, regarding nursing practice and education, and some aspects of forensic practice generally. However this researcher is cognisant of how changes in practice, and in organisational structure is often necessary to implement findings effectively. With this fact in mind further recommendations will be made as to overcoming potential obstacles within organisations, MSU's in particular. Similarly, any contribution to the knowledge that this study has made, or will make, will be closely linked to peer review, impact and dissemination. As a consequence a dissemination schedule of a proposed research report will be incorporated into the recommendations made within this chapter.

6.1: Answering the Questions

The constraints of access and ethical approval in some ways limited the sample of patients within this study (n=117). The 117 patients within the target population of three MSU's constitute 8.7% of the English and Welsh MSU population combined. However the finding that 41% of this target population had been abused or neglected in childhood or adolescence did establish prevalence, one of the aims of this work outlined in Chapter One. This is likely to be a case of under reporting, in that we must not assume that a lack of documented evidence of childhood abuse/neglect constitutes non-existence (see Glasser et al 2001, Chapter Two). It would appear from such a prevalence finding that the concerns and focus of a range of authors, on victimology and working with victims of abuse in forensic practice, is justified. Certainly Tarbuck (1994) (see Chapter Two) suggested that such activity amongst FMHN's should be considered a core skill.

The study was also able to secure data which provided a patient profile within MSU's. This question within Chapter One was particularly interested in the prevalence of specific

diagnoses, index offence, behaviour, age and gender, as well as legal and marital status. Findings which revealed a predominantly male population, 37 or 38 years of age, suffering schizophrenia, who are likely to be restricted under the Mental Health Act, be Caucasian and single, having committed a violent index offence, concurred with other national findings in this area. This profile was unsurprising, but confirmed a profile which could be contextualised with the prevalence of abuse finding.

The probability of both childhood abuse and neglect and having committed a violent index offence was determined. However this is an area where more specific and more sophisticated work could be undertaken in the future. The probability found is not as generalisble as other findings in this work, considering the sample size (n=117) used in this study. Grimm (1993, p494) writes of the posteriori approach to probability (an empirical approach, requiring the collection of data) and the requirement of a large sample to determine probability more accurately. However the a priori determination within this study has illustrated an approach, which could be taken further in studies with larger samples.

Analysis of association on one set of variables was undertaken as per the research question linked to patient data collection posed in Chapter One. The alternative hypothesis, was supported ($p < 0.05$), this association being found between two variables only: gender and abuse/neglect suffered. The lack of statistical association between other variables however does not negate the clinical significance of findings such as 77.8% of the sample being single, and there being very high numbers of males, and diagnosis of schizophrenia (81.2%) in the sample. Certainly the qualitative analysis of the rationale for admission of the 6% of patients who had non-violent index offences would be of interest. Similarly the examination of factors of discontinuation in having been abused and not committing a violent offence would also be worthy of further study in this sample, and in larger MSU samples. The significance found in association between gender and abuse/neglect suffered is of interest to this work, and answered one of the questions in Hypotheses One in Chapter One. The finding is illustrative of one of the areas of address required in the establishment of women's services within forensic service development. That such a high proportion of female patients in this sample (n=117), nineteen out of twenty-six, were abused in childhood and/or adolescence is of

concern. It would appear that because of such numbers specific schema of intervention, if clinically appropriate, should be specifically developed for female patients. However such wholesale of adoption of revised and developed programmes of intervention with this patient group would likely benefit from the replication of similar data collection concerning female abuse in a more extended range of medium secure settings.

The aims of the research were also linked to exploring the levels of experience that staff working in medium secure environments have. This experience was clearly great, if we consider that ten years plus experience is indicative of positive experience, which was the finding in the majority of data collected from both the severity of maltreatment questionnaire (nurse respondents) and the knowledge and opinions questionnaire (clinician respondents including nurses). I recollect a rather disparaging remark made to me by a colleague during my nurse training, when I had commented upon a Nursing Sister who had reported to me quite grandly that she had twenty-five years experience in the NHS. The colleague, in response, wryly suggested that the Nursing Sister in question had likely had one year's experience, twenty-five times over. I remembered this comment when examining both the evidence of a great deal of experience in years amongst nurses and other clinicians in this study, but scant evidence of a consistent approach to continuous professional development amongst nursing staff surveyed. This observation is definitely not intended to suggest a wholesale lack of positive experience amongst nursing staff, but rather to illustrate that this research has:

- Indicated a need to further address what experience means in terms of forensic practice, taking into account that the forensic service seems to attract many staff who have long periods of health service experience behind them. Alternatively the retention of staff may be better than in other environments, which is still an issue worthy of further examination

- Found that the post-registration qualification profile of FMHN's appears to be heterogeneous, which is not necessarily a negative finding, rather it could be quite positive. However it is more likely to be perceived as positive if uptake of CPD was above two thirds amongst nursing staff, as well as being consistently more than basic CPD in nature, as was found in this study

The focus of this study looked to quantitative and qualitative analysis of clinical decision making/agreement amongst nurses, against a Benchmark nurse, regarding severity of maltreatment classification. Whilst findings that are heterogeneous in this area are interesting in themselves, when coupled with heterogeneous findings in terms of CPD uptake, one cannot help but recognise avenues for future work in this area, particularly related to stasis in clinical development and implementation of research and evidence based practice. An innovative methodological approach combining quantitative and qualitative analysis contributed to answering a further question outlined in Chapter One, related to variation among professional groups in terms of knowledge and opinion regarding concepts of abuse, violence and mental disorder. An analysis of variance (ANOVA) revealed no difference between professions mean levels of agreement/non-agreement for a series of statements related to these concepts. However differences between the professions were revealed in themed qualitative analysis of the rationale given for responses. The degree of triangulation in this work has illustrated how multi method approaches to mental health care research can provided a range of different representations of observed phenomenon.

6.2. The Contribution to Knowledge and Practice: Implication of this Study to both Areas

There are few forensic mental health research studies which combine examination and exploration of:

- The inter-rater reliability of a large staff group employed in forensic settings
- Specific clinical phenomena as well as the knowledge and skills associated with rating such phenomena
- The knowledge and opinions of professional groups of staff working in MSU's related to the key clinical variables with which they work
- A descriptive data evaluation of the patient profile within MSU's, to both profile and confirm the key clinical variables of address
- Gaps within FMHN research and practice
- A review of consistency of clinical agreement between a group of expert nurse practitioners (a newly developed professional role)

- The reliability of a specific clinical classification scale
- The combination of a positivist and interpretivist methodological approach

These areas have all been addressed within this study to varying degree. The advantages of such a wide area of address is related to the many avenues of education and practice development, which can occur as a consequence of such work. As a researcher who works in both education and practice arenas the work has confirmed my own understanding of a cautious workforce, who are consistently reporting their frequent contact with an abused patient group. Further to this they (nurses and clinicians in both the study surveys) tend to relate a variable understanding of the literature and evidence base related to abuse, characteristics, prevalence and association with mental disorder and violence. This understanding would be helped by changes to certain educational curricula. My role, as an external examiner, to a developing forensic nursing degree programme in Northern Ireland, as well as a course team member on an MSc forensic study course in a West Midlands University, will contribute to the impact that this study can have. Further to this my role within the health practice areas will aid the process of disseminating findings, in both publication and teaching formats. The argument, in the first instance, will be to ensure a honed inclusion of research and literature (covered in Chapter Two) supported by research findings included within this study, into specific educational provision in both University and Trust settings. Forensic educational courses will be the focus of address, however course provision related to family therapy, psychosexual counselling and cognitive therapy would also benefit from a module relating prevalence of childhood abuse and neglect, and a review of work examining association, and methodological approaches to addressing mediating factors between clinical variables of abuse and mental disorder, and abuse and violent behaviour.

However in utilising research findings it is worth remembering how professional groups such as nurses are steeped in clinical practice. It is not always the case that good intentions in education and research find their way into clinical practice. Some of the findings within this study relate directly to clinical practice, particularly the practice associated with those patients

who have been abused or maltreated in childhood and/or adolescence. That this practice had been examined within a specific context, (the rating of severity of maltreatment), should not detract from the importance of inconsistency being found, against a gold standard. But the more positive observation that agreement had been calculated as better than by chance should be acknowledged. There is clearly scope for improvement, particularly in improving knowledge base and confidence of nursing staff in rating their own competency to rate severity of abuse suffered, and this can be tackled in practice. A research report will be generated from this work and it is intended that each MSU within this study, and each UK MSU, will receive a copy. The report will contain a summary of the findings and the rationale for undertaking this study, with a brief overview of key findings and ongoing developments of educational curricula, which this researcher will likely be able to influence. I will target Directors of Nursing, Nurse Consultants, Lead Clinicians and Lecturer Practitioners working in secure units, as well as higher education establishments which run appropriate educational courses of study. The research report will also detail specific findings concerning gaps within clinical documentation. The address of such gaps would enable a more rich patient profile to be compiled. Suggestions for the development of clinical data sheets, in forensic environments which might facilitate the routine documentation of trauma, associated with childhood abuse, neglect or maltreatment suffered by patients in such environments will be made. Some units already have documentation systems which are good, or adequate, for this purpose, however with the added pressures on nurses and other clinicians in an ever changing health service I feel that such suggestions will be favourably considered, as opposed to being viewed as intrusive or arrogant in discussing improvement in this area..

It is highly probable that all, or at least elements, of this study will have further impact via publication. There are three publications listed in the appendices of this work which are linked to this research, having been published (or presented at conference) over the last two years. The recent conference presentation made at Salford University (see Appendix Four) was directly linked with the core of this study, and was well received. An audience, comprising users, carers and professional health care workers were particularly interested in the association found between gender and abuse/neglect suffered in this study, and how this

finding might influence the interventions established within newly developing women's services.

Many nurse researchers feel hidebound by either a positivist or interpretivist approach to research, and this study had indicated the usefulness of combining both methods of approach, as well as utilising an inter-rater reliability test not frequently used within nursing practice, the Kappa chance corrected statistical test. The qualitative use of themed analysis of rationale provided by both nurses and clinicians in two different questionnaires proved to very illuminating, particularly in revealing some differences between findings when employing qualitative and quantitative analysis in the same study.

The abuse and maltreatment suffered by some patients during childhood and adolescence is both distressing, and can be an important part of an individual's psychopathology. Such information, particularly when given by a patient suffering psychological distress in adulthood which could be related to such abuse, deserves to be both documented and considered in a manner which befits the courage it had taken to disclose. There should therefore be scope within clinical notes to document such information, in a way, which corresponds with the significance of the disclosure. This study has undertaken an address of an area which some may have considered to be unethical, particularly considering the collection of information from clinical notes of stories of distress and sometimes brutal abuse experienced by patients. However this research study has endeavoured to be both ethical and professional in its approach to what is undoubtedly sensitive information. The study has been ever aware of the distressing circumstances related in much of its subject matter. However uncomfortable, or sensitive the subject matter the researchers responsibility, as illustrated by Parahoo (1997 p377) is to make findings relevant to clinical practice. The responsibility of this researcher will now be to make explicit the findings to both nursing education and practice, and more generally in forensic education and practice.

REFERENCES

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Ah leh Appel., Malcolm, P.A. (1998) Specialist Education and Practice in Nursing: An Australian Perspective. *Nurse Education Today*, 18, pp. 144-152.

Alexander, J.E. (1989). Patricia Benner. From Novice to Expert. Excellence and Power in Clinical Nursing Practice pp. 187-199. In: Marriner-Tomey, A. (ed) *Nursing theorists and their work*, (2nd ed.). Mosby. St Louis.

American Psychiatric Association (1980) *Diagnostic and statistical manual of mental disorders* (3rd edn.). American Psychiatric Association. Washington DC.

American Psychiatric Association (1994) *Diagnostic and statistical manual of mental disorders* (4th edn.). American Psychiatric Association. Washington DC.

Appleby, L., Shaw, J., Amos, T., McDonnell, R. (1999) *Safer Services: National confidential inquiry into suicide and homicide by people with mental illness*. Department of Health. London.

Appleby, L. (2000) A New Mental Health Service: high quality and user led. Editorial. *The British Journal of Psychiatry*, 177, October, pp. 290-291.

Archer, J., Browne, K.D. (1989) Concepts and approaches to the study of aggression pp. 3-24. In: Archer, J., Browne, K.D. eds. *Human Aggression: Naturalistic Approaches*. London. Routledge.

Badger, D. Woodward, M. Williams, P. Nursten, J. (1999) Systematic review of the International Literature on the epidemiology of mentally disordered offenders. *NHS Centre for Reviews and Dissertation*. CRD Report 15. University of York.

Bailey, D (1996) Services for Mentally Disordered Offenders: a literature review. *Social Services Research,* 3, pp. 31-57.

Bandura, A. (1973) *Aggression: A social learning analysis*. Englewood Cliffs, NJ. Prentice Hall.

Barer, D. (2002) URL. Dysphagia is a common and potentially serious complication of stroke. http://www.ncl.ac.uk/stroke-research-unit/posters/ssaintl.htm

Beacock, C. (1994) A Journey without end. Creating a development Strategy for Staff in Secure forensic settings pp. 535 –551. In: Thompson, T., Mathias, P. eds. L*yttles Mental Health and Disorder* (2nd ed). Balliere Tindall. London.

Benner, P. (1984) *From Novice to Expert: Excellence and power in clinical nursing practice*. Addison Wesley. Mento Park. California.

Besharov, J.D. (1982) Toward better research on child abuse and neglect: Making definition issues an explicit methodological concern. *Child Abuse and Neglect*, 5, pp. 383-390.

Blackburn, R. (1989) Psychopathy and Personality Disorder in Relation to Violence pp. 61-89. In: Howells, K., Hollin, C.R. eds. *Clinical Approaches to Violence*. John Wiley and Sons. Chichester.

Blackburn, R. (1993) The psychology of criminal conduct: *Theory, research and practice*. Chichester. Wiley.

Blackburn, R. (1995) *The psychology of criminal conduct: Theory, research and practice* (paperback edition). Chichester. Wiley.

Blumenthal, A., Lavender, T. (2000) *Violence and mental Disorder*. Jessica Kingsley. London.

Boudewyn, A.C., Liem, J.H. (1995) Childhood sexual abuse as a precursor to depression and self-destructive behaviour in adulthood. *Journal of Traumatic Stress*, 8 (3), pp. 445-459.

Brierè, J., Runtz, M. (1988a) Multivariate correlates of childhood psychological and physical maltreatment among university women. *Child Abuse and Neglect*, 12, pp. 331-341.

Brierè, J., Runtz, M. (1988b) Post sexual abuse trauma pp. 85-99. In: Wyatt, G.E., Powell, G.J. eds. *Lasting effects of child sexual abuse*. Sage. CA.

Browne, K. (1988) The nature of child abuse and neglect: An overview pp. 15-30. In: Browne, K. Davies, C., Stratton, P. eds. *Early prediction and prevention of child abuse*. John Wiley and Sons. London.

Browne, K.D. (1989) A health visitors role in screening for child abuse. *Health Visitor*, 62, pp. 275-277.

Browne, K.D. (1993) Violence in the family and its links to child abuse. *Ballière's Clinical Paediatrics*, 1(1), February, pp. 149-164.

Browne, K., Herbert, M. (1997) *Preventing family violence*. Chichester. Wiley.

Buchanan, A. (1997) The investigation of acting on delusions as a tool for risk assessment in the mentally disordered. *The British Journal of Psychiatry*, 170, supplement 32, pp. 12-16.

Burke, H., Hart, S.D. (2000) Personality disordered Offenders: Conceptualization Assessment and Diagnosis of personality disorder pp. 63-85. In: Hodgins, S., Muller-Isberner, R. eds. *Violence, Crime and Mentally Disordered Offenders*. John Wiley and Sons. Chichester.

Burrow, S. (1993a) The Role Conflict of the Forensic Nurse: Facilitating the health management of the mentally abnormal offender. *Senior Nurse*, 13, pp. 20-25.

Burrow, S. (1993b) Inside the Walls. Work of the nursing staff in special hospitals and secure units. *Nursing Times*, 89, pp. 38-40.

Cahill, R. (1997) Choosing between qualitative and quantitative approaches. *N.T. Research*, 2 (3), pp. 185-186.

Carmen, E., Rieker, P., Mills, T. (1984) Victims of violence and psychiatric illness. *American Journal of Psychiatry*, 141, pp. 378-383.

Carper, B. (1978) Fundamental patterns of knowing in nursing. *Advances in Nursing Science*, 1(1), pp. 13-23.

Carton, G. (1998) Nurse Education: Scribes and Scriptures. pp. 244-255. In: Mason, T., Mercer, D. eds. *Critical perspectives in forensic care: Inside out.* Macmillan. London.

Chalder, G., Nolan, P. (2001) The role of the forensic nurse consultant observed. *British Journal of Forensic Practice*, 3(3) October, pp. 23-31.

Chaloner, C. (2000) Characteristics Skills Knowledge and Inquiry. pp. 1-21. In: Chaloner, C., Coffey, M. eds. *Forensic Mental health nursing current approaches.* Blackwell Science. Oxford.

Chaloner, C., Coffey, M. eds. (2000) *Forensic mental health Nursing current approaches.* Blackwell Science. Oxford.

Chiswick, D. (1985) The special Hospitals: a problem of clinical credibility. *Bulletin of the Royal College of Psychiatrists*, 6, pp. 130-132 (698).

Cohen, J. (1960) A coefficient of agreement for nominal scales. *Educational and Psychological Measurement*, 20, pp. 37-46.

Cole, P.M., Putman, F.W. (1992) Effect of incest on self and social functioning, a developmental psychopathology perspective. *Journal of Consulting and Clinical Psychology*, 60(2), pp. 174-184.

Collins, M. (2000) The Practitioner new to the role of forensic psychiatric nurse in the UK pp. 39-51. In: Robinson, D., Kettles, A. eds. *Forensic Nursing and multidisciplinary care of the mentally disordered offender.* Jessica Kingsley. London.

Cope, R. (2001) Foreword. In: McClelland, N., Humphreys, M., Conlon, L., Hillis, T. (2001) eds. *Forensic Nursing and Mental Disorder in Clinical Practice.* Butterworth-Heinemann. Oxford.

Corby, B. (1993) *Child abuse. Toward a knowledge base.* Open University Press. Buckingham. Philadelphia.

Cox, C.L. (2000) The Nurse Consultant. An advanced Nurse Practitioner. *Nursing Times*, March 30, 96 (13), p. 48.

Creighton, S.J. (1988) The incidence of child abuse and neglect. pp. 31-41. In: Browne, K. Davies, C., Stratton, P. eds. *Early prediction and prevention of child abuse*. John Wiley and Sons. London

Crittenden, P. (1988) Family and dyadic patterns of functioning in maltreating families. pp. 161-189. In: Browne, K. Davies, C., Stratton, P. eds. *Early prediction and prevention of child abuse*. John Wiley and Sons. London.

Cutcliffe, J.R. (1998) Is psychiatric nursing research barking up the wrong tree. *Nurse Education Today*, 18, pp. 257-258.

Curtis, G.C. (1993) Violence breeds violence – perhaps? *American Journal of Psychiatry*, 120, p. 386-387.

De Bellis, M.D., Broussard, E.R., Herring, D.J., Wexter, S., Moritz, G., Benitez, J.G. (2001) Psychiatric co-morbidity in caregivers and children involved in maltreatment – A pilot research study with policy implication. *Child Abuse and Neglect*, 25, pp. 923-944.

Department of Health (1981) *Working together under the children act 1989: A guide to arrangements for inter-agency cooperation for the protection of children from abuse*. London. HMSO.

Department of Health (1985) Children and young persons on child protection registers – Year ending 31 March 1995, England, Personal social services local authority statistics. London. HMSO.

Department of Health and Home Office. (1992a) *Review of Health and Social Services for mentally Disordered Offenders and Others Requiring Similar Services (Reed Report)*. London. HMSO.

Department of Health (1992b) *Report of the Committee of Inquiry into Complaints about Ashworth Hospital* (The Blom Cooper Report). HMSO. London.

Department of Health (1999a) *Making a difference: Strengthening the contribution of Nursing, Midwifery and Health Visiting*. London. The Stationery Office.

Department of Health (1999b) *The National Service Framework for mental health. Modern Standards and service models*. London. Department of Health.

Department of Health (1999c) *Working together to safeguard children. A guide to inter-agency working to safeguard and promote the welfare of children*. HMSO. London.

Department of Health (DOH) (2000-2001) *Medium Secure Services Database and Summary Reports V2 (Survey for Adults with a Mental Illness)* CD- Rom.

Department of health and Social Security (DHSS) (1974) *Revised report of the working party on security in NHS.* Psychiatric Hospitals *(The Glancy Report).* HMSO. London.

Deveson, A. (1982) Violence in Society pp. 231-237. In: Oates, K. ed. *Child Abuse. A community concern.* Butterworth. London.

DHSS (1980) *Department of health and Social Security. Report of the Committee of Inquiry into Rampton Hospital.* CMND 8073. HMSO. London.

DoH (2001 URL) http// www.doh.gov.uk/public/cpr2001.htm

Downs, W.R., Millar, B.A. (1998) Relationships between experiences of parental violence during childhood and womens psychiatric symptomatology. *Journal of Interpersonal Violence*, 13 (4), August, pp. 438-455.

Doyle-Peters, S. (1988) Child sexual abuse and later psychological problems pp. 101-119. In: Wyatt, G.E., Powell, G.J. eds. *Lasting effects of child sexual abuse.* Sage. CA.

Duffy, M.E. (1985) Designing nursing research: the qualitative – quantitative debate. *Journal of Advanced Nursing*, 10, pp. 225-232.

Dutton, D.G., Hart, S.D. (1992) Evidence for long term, specific effects of childhood abuse and neglect on criminal behaviour in men. *International Journal of Offender Therapy and Comparative Criminology*, 36, pp. 129-137.

Everitt, B.S. (1992) *The analysis of contingency tables* (2nd ed). Chapman and Hall. London.

Fallon, P., Bluglass, R., Edwards, B., Daniels, G. (1999) *The Report of the Committee of Inquiry into the personality disorder unit, Ashworth Special Hospital.* CM 4194-11. The Stationary Office. London.

Farrar, M. (1996) Government Policy on mentally disordered offenders and its implementation. *Journal of Mental Health,* 5, pp. 465-474.

Faulk, M. (2000) *Faulk's Basic Forensic Psychiatry* (3rd ed) Revised by: Stone, J.H., Roberts, M., O'Grady, J., Taylor, A.V., O'Shea, K. Blackwell Science. Oxford.

Fergusson, D.M., Horwood, L.J., Woodward, L.J. (2000) The stability of child abuse reports: A longitudinal study of the reporting behaviour of young adults. *Psychological Medicine*, 30, pp. 529-544.

Fiering, C., Taska, L., Lewis, M. (1999) Age and gender differences in childrens and adolescents adaptation to sexual abuse. *Child Abuse and Neglect*, 23(2), pp. 115-128.

Finklehor, D. (1979) *The sexual victimisation of children.* Free Press. New York.

Finklehor, D. (1981) *Sexually victimised children*. Free Press. New York.

Finklehor, D. (1988) The trauma of child sexual abuse: Two models pp. 61-83. In: Wyatt, G.E., Powell, G.J. eds. *Lasting effects of child sexual abuse*. Sage. CA.

Finklehor, D., Baron, L. (1986) Risk factors for child sexual abuse. *Journal of Interpersonal Violence*, 1(1), pp. 43-71.

Fitch, F.J., Papantonio, A. (1983) Men who batter: some pertinent characteristics. *Journal of Nervous and Mental Disease*, 171, pp 190-192.

Fondacarro, K.M., Holt, J.C., Powell, T.A. (1999) Psychological impact of childhood sexual abuse on male inmates: The importance of perception. *Child Abuse and Neglect,* 23(4), pp. 361-369.

Forshaw, D., Rollin, H. (1990a) S1: 6 The history of Forensic Psychiatry in England. In: Bluglass, R., Bowden, P. eds. *Principles and Practice of Forensic Psychiatry*. Churchill Livingston. London.

Freshwater, D., Rolfe, G. (2001) Critical reflexivity – A politically and ethically engaged research method for nursing. *N.T. Research*, Special Issue, Research Methodologies, 6 (1), pp. 526-537.

Garbarino, J., Gillam, G. (1980) *Understanding abusive families*. Lexington Books. New York.

Garner, R., Butler, G. (1994) Learning from acts of deliberate self-harm. A study of self inflicted injury in a secure unit. *Psychiatric Care* (Nov-Dec), pp. 197-201.

Gelles, R.J., Cornell, C.P. (1990) Intimate violence in families (2nd ed.). Beverly Hills, CA. Sage.

Giddens, A. (1979) Positivism and its critics pp. 237-286. In: Bottomore, T., Nisbet, R.A. eds. *A history of sociological analysis*. Heinemann. London.

Gil, D. (1975) 'Unraveling child abuse'. *American Journal of Orthopsychiatry*, 45, pp. 346-356.

Glasser, M., Kolvin, I., Campbell, D., Glasser, A., Leitch, I., Farrelly, S. (2001) Cycle of child sexual abuse: Links between being a victim and becoming a perpetrator. *British Journal of Psychiatry*, 179, pp. 482-494.

Goremann, I., Zunzunegui, M.V., Martinez, C., Onis, M.D. (1999) Screening for impaired cognitive function among the elderly in Spain: reducing the number of items in the short portable Mental Status Questionnaire. *Psychiatric Research*, Dec 20, 89 (2), pp. 133-145.

Greenwood, J. (2000) Critique of the Graduate Nurse: an international perspective. *Nurse Education Today*, 20, pp. 17-23.

Grimm, L.G. (1993) *Statistical applications for the behavioural sciences.* John Wiley and Sons Inc. New York.

Groth, A.N., Burgess, A. (1979) Sexual trauma in the life histories of rapists and child molesters. *Victimology*, 1(1), pp. 10-16.

Grounds, A., Snowden, P., Taylor, P.J. (1995) Forensic Psychiatry in the NHS of England and Wales. In: Gunn, J., Taylor, P. eds. *Forensic Psychiatry – Clinical Legal and Ethical Issues.* Butterworth Heinemann. Oxford.

Grubin, D. (1997) Predictors of risk in serious sex offenders pp. 17-22. *British Journal of Psychiatry*, April, 170, supplement 32.

Guba, E. (1990) *The paradigm dialog.* Sage. Newbury Park. CA.

Guba, E., Lincoln, Y. (1994) Competing paradigms in qualitative research pp. 105-117. In: Denzin, N.K., Lincoln, Y.S. eds. *Handbook of qualitative research.* Sage. Thousand Oaks. CA.

Gunn, J., Taylor, P. (1995) Introduction pp. 1-20. In: Gunn, J., Taylor, P. *Forensic Psychiatry – Clinical Legal and Ethical Issues.* Butterworth Heinemann. Oxford.

Hafner, H., Boker, W. (1973) *Crimes of Violence by Mentally Abnormal Offenders. A Psychiatric and Epidemiological Study in the Federal German Republic.* (Trans. Marshall, H.1982). Cambridge University Press. Cambridge.

Hamilton, J.R. (1987) Violence and Victims. The Contribution of Victimology to Forensic Psychiatry. *The Lancet*, January 17, pp. 147-150.

Hanrahan, P., Campbell, J., Ulrich, Y. (1993) Theories of violence pp. 3-35. In: Campbell, J., Humphries, J. *Nursing care of survivors of family violence.* Mosby. St. Louis.

Hare, R.D. (1991) *Manual for the Hare Psychopathy checklist – Revised.* Toronto. Multi-Health Systems.

Hare, R.D., Hart, S.D. (1993) Psychopathy, Mental Disorder and crime pp. 104-115. In: Hodgins, S. ed. *Mental Disorder and Crime.* Sage. Newbury Park. CA.

Hart, S.D., Hare, R.D., Forth, A.E. (1994) Psychopathy as a risk marker for violence: Development and validation of a screening version of the revised psychopathy checklist pp. 81-89. In: Monahan, J, Steadman, H.J. eds. *Violence and Mental Disorder. Developments in risk Assessment.* The University of Chicago Press. Chicago.

Hermann, J.L., Perry, J.C., Van der Kolk, B.A. (1989) Childhood trauma in borderline personality disorder. *American Journal of Psychiatry*, 146, pp. 490-495.

Herzberger, S.D. (1983) Social cognition and the transmission of abuse pp. 317-329. In: Finklehor, R.J., Gelles, G.T., Hotaling, G.T., Straus, M.A. *The dark side of families: Current family violence research.* Sage. CA.

Hiday, V.A., Swart, M.S., Swanson, J.W., Borum, R., Wagner, H.R. (1999) Criminal victimisation of persons with severe mental illness. *Psychiatric Services*, 50, pp. 62-68.

Hill-Bailey, P. (1997) Finding your way around qualitative methods in nursing research. *Journal of Advanced Nursing*, 25, pp. 18-22.

Hodgins, S. (1992) Mental disorder, intellectual deficiency, and crime. Evidence from a birth cohort. *Archives of General Psychiatry*, 49, pp. 476-483.

Hodgins, S. (1993) The criminality of mentally disordered persons pp. 3-22. In: Hodgins, S. ed. *Mental disorder and crime.* Sage. Newbury Park. California.

Hollin, C.R., Howells, K. (1989) An Introduction to Concepts Models and Techniques pp. 3-25. In: Howells, K., Hollin, C.R. eds. *Clinical Approaches to Violence.* John Wiley and Sons. London.

Holloway, I., Fullbrook, P. (2001) Revisiting qualitative inquiry: Interviewing in nursing and midwifery research. *N.T. Research*, Special Issue, Research Methodologies, 6 (1), pp. 539-550.

Home Office, Department of Health and Social Security (1975) *Report of the Committee on Mentally Abnormal Offenders (The Butler Report).* CMND. 6244. HMSO. London.

Honey, P., Mumford, A. (1992) *The manual of learning styles* (3rd ed). Peter Honey. Maidenhead.

Horowitz, L.M., Wong, P.S., Koocher, G.P., Burr, B.H., Smith, M.F., Klavon, S., Cleary, P.D. (2001) Detecting suicide risk in a paediatric emergency department. Development of a brief screening tool. *Paediatrics*, May, 107(5), pp. 1133-1137.

Howard, W.T., Loberiza, F.R., Pfohl, B.M., Thorne, P.S., Maypantay, R.L., Woolson, R.F. (1999) Initial results, reliability and validity of a mental health survey of Mount Pinatuto disaster victims. *Journal of Nervous Mental Disorder*, Nov, 187 (11), pp. 661-672.

Howells (1982) Mental Disorder and Violent Behaviour pp.163-200. In: Feldman, P. ed. *Developments in the study of criminal behaviour. Vol. 2. Violence.* John Wiley and Sons. London.

Humphreys, J., Ramsey, A.M. (1993) Child Abuse pp. 36-67. In: Campbell, J., Humphreys, J. eds. *Nursing care of survivors of family violence.* Mosby. St Louis.

Huws, R., Shubsachs, A. (1993) A study of absconding by special hospital patients, 1976-1988. *Journal of Forensic Psychiatry,* 4, pp. 45-58.

Isohanni, M., Winblad, I., Nieminen, P., Hiltunen, P., Spaldin, M. (1996) A short DSM III-R-Based diagnostic instrument for screening mental disorder in generic institutions. *International Psychogeriatrics*, 8 (3) – fall, pp. 459-468.

Junginger, J. (1990) Predicting Compliance with command Hallucinations. *American Journal of Psychiatry*, 47, pp. 245-247.

Junginger, J. (1995) Command Hallucinations and the Prediction of Dangerousness. *Psychiatric Services*, 46, pp. 911-914.

Kaufman, J., Zigler, E. (1987) Do abusers become abusive parents? *American Journal of Orthopsychiatry*, 57(2), pp. 186-192.

Kaufman, J., Zigler, E. (1993) The intergenerational transmission of abuse is overstated pp. 209-221. In: Gelles, R.J., Loeske, D.R. eds. *Current Controversies on family violence*. Sage. CA.

Kempe, C.H., Silverman, F.N., Steele, B.F., Droegmueller, W., Silver, H.K. (1962) The Battered Child Syndrome. *Journal of the American Medical Association*, 181, pp. 17-26.

Kettles, A. M., Robinson, D.K. (1998) The Lost Vision of Nursing. *Psychiatric Care*, 5(4), pp. 126-129.

Kettles, A.M., Robinson, D.K. (2000) Overview and contemporary issues in the role of the Forensic Nurse in the UK pp. 26-39. In: Robinson, D., Kettles, A. eds. *Forensic Nursing and Multidisciplinary care of the Mentally Disordered Offender*. Jessica Kingsley. London.

Kettles, A.M., Robinson, D.K. (2000) From a reactive past into the proactive new millennium pp. 267-279. In: Robinson, D., Kettles, A. eds. *Forensic Nursing and Multidisciplinary care of the Mentally Disordered Offender*. Jessica Kingsley. London.

Kettles, A.M., Taylor, C.P., Woods, P., Hufft, A., Van Erven, T., Martin, H., Dorisch-Siedel, U., Kuppen, A., Holmes, C., Almvik, R., Hatling, T., Robinson, D.K. (2001) Forensic Nursing: A global perspective. *British Journal of Forensic Practice*, 3(2), July, pp. 29-41.

Kirby, S.D., Maguire, N.A. (1997) Forensic Psychiatric Nursing pp. 395-409. In: *Stuart and Sundeens Mental Health Nursing: Principles and Practice*. Mosby. London.

Kitchener, N., Wright, I., Topping–Morris, B. (1992) The Role of the Forensic Nurse. *Nursing Times*, 91(25), pp. 11-12.

Kolb, D.A. (1984) *Experiential Learning. Experience as the source of learning and development*. Englewood Cliffs. Prentice Hall. New Jersey.

Kratcoski, P.C. (1982) Child abuse and violence against the family. *Child Welfare*, LX1 (7), September-October, pp. 453-444.

Lafontaine, J. (1990) *Child sexual abuse*. Cambridge. Polity Press.

Lakatos, I. (1981) History of science and its rationale reconstructions pp. 107-127. In: Hacking, I. ed. *Scientific Revolution*. University Press. Oxford.

Landis, J.R., Koch, G.G. (1977) The measurements of observer agreement for categorical data. *Biometrics*, 33, pp. 159-174.

Lewis, D.O., Shanock, S.S., Pincus, J.H., Glaser, G.H. (1980) Violent juvenile delinquents: Psychiatric, psychological and abuse factors. *Annual Progress in Child Psychiatry and Child Development*, pp. 591-603.

Lindqvist, P., Allebeck, P. (1990) Schizophrenia and crime: a longitudinal follow up of 644 schizophrenics in Stockholm. *British Journal of Psychiatry*, 157, pp. 345-350.

Link, B.G., Stueve, A. (1994) Psychiatric Symptoms and the Violent Illegal Behaviour of Mental Patients compared to Community Controls pp. 137-161. In: Monahan, J., Steadman, H.J. eds. *Violence and Mental Disorder. Developments in Risk Assessment*. University of Chicago Press. Chicago.

Lipley, N. (2000) Survey finds Consultant Nurse posts hard to fill. *Nursing Standard*, 15(2), 27 September, p. 4.

Lipley, N. (2001) New Recruitment drive to fill Consultant Nurse posts. *Nursing Standard*, 15 (33), 2 May, p. 7.

Lucas, B., Harrison-Read, P., Rapp, D. (1997) Falling through the net: discrepancies between community mental health services and primary care services in care plans for patients recently discharged from a community mental health team. *Journal of Interprofessional Care*, 11 (3), pp. 303-311.

Macmillan, H.L., Munn, C. (2001) The sequelae of child maltreatment. *Current Opinion in Psychiatry*, 14(4), pp. 325-331.

Maden, A., Curle, C., Meux, C., Burrow, S. and Gunn, J. (1993) The treatment and security needs of patients in special hospitals. *Criminal Behaviour and Mental health,* 3: 290-306.

Marshall, W.L., Barbaree, H.E. (1989) Sexual violence pp. 205-250. . In: Howells, K., Hollin, C.R. eds. *Clinical Approaches to Violence*. John Wiley and Sons Ltd. Chichester.

Mason T., Mercer, D. (1996) Forensic Psychiatric Nursing; visions of social control. *Australian New Zealand Journal of Mental Health Nursing*, 5, pp. 153-162.

Mason, T., Chandley, M. (1990) Nursing models in a Special Hospital: a critical analysis of efficacy. *Journal of Advanced Nursing*, 15, pp. 667-673.

Mason, T., Mercer, D. (1998) Forensic Psychiatric Nursing pp. 236-360. In: Clinton, M., Nelson, S. (1999) eds. *Advanced Practice in Mental Health Nursing*. Blackwell Science. Oxford.

Meyer, J., Bukehup, L. (1997) Action research in health care practice: Nature, present concerns and future possibilities. *N.T. Research*, 2 (3), pp. 175-184.

McCann, G. (1996) Speaking Terms. Nurses in forensic institutions could play a major role in reducing their own isolation. *Nursing Times*, 92, p. 52.

McClelland, N. (1995) The assessment of dangerousness: a procedure for predicting potentially dangerous behaviour. *Psychiatric Care*, (2) 1, p. 17-20.

McClelland, N. (2001) Assessment and Clinical Risk pp. 11-20. In: McClelland, N., Humphreys, M., Conlon, L., Hillis, T. eds. *Forensic Nursing and mental Disorder in Clinical Practice*. Butterworth Heinemann. Oxford.

McClelland, N., Cutler, J. (2001) Education and Training pp. 105-113. In: McClelland, N., Humphreys, M., Conlon, L., Hillis, T. eds. *Forensic Nursing and Mental Disorder in Clinical Practice*. Butterworth Heinemann. Oxford.

McClelland, N., Humphreys, M., Conlon, L., Hillis, T. (2001) eds. *Forensic Nursing and Mental disorder in Clinical Practice*. Butterworth Heinemann. Oxford.

McClelland, N. (2002) *Issues related to previous abuse and diagnosis. A research study in Medium Secure Units*. Unpublished. The University of Salford. Faculty of Health and Social Care. School of Nursing. Conference: Personality disordered people with complex needs. April 2002.

McClelland, R.J., Yolles, M.I. (1997) *The cybernetics of learning environments*. Cti-afm. 8th Annual Conference. Newport Gwent. 8/9th April 1997.

McHugh, A., Wain, I., West, M. (1995) Handle with care. *Nursing Times*, 91(6), pp. 62-63.

McNeil, D.E. (1994) Hallucinations and Violence pp. 183-202. In: Monahan, J, Steadman, H.J. eds. *Violence and Mental Disorder. Developments in Risk Assessment*. The University of Chicago Press. Chicago.

McKenna, H. (1997) *Nursing theories and models*. Routledge. London.

Mercer, D. (1999) Crime Mental Disorder and Criminology: a critical perspective. In: Tarbuck, P., Topping-Morris, B., Burnard, P. eds. *Forensic Mental Health Nursing: Strategy and Implementation*. Whurr. London.

Mercer, D., Mason, T., McKeown, M., McCann, G. (2000) *Forensic Mental Health Care. A case study approach*. Churchill Livingstone. London.

Millar, P.M., Lisak, D. (1999) Associations between childhood abuse and personality disorder symptoms in college males. *Journal of Interpersonal Violence*, 14 (6), June, pp. 642-656.

Ministry of Health (1961) *Special Hospitals: Report of a working party* (The Emery Report). HMSO. London.

Morrison, P., Burnard, P. (1992) *Aspects of Forensic Psychiatric Nursing.* Aylesbury. Avebury.

Mullen, P.E. (1993) Child Sexual Abuse and Adult Mental Health. The Development of Disorder. *Journal of Interpersonal Violence*, 8(3), September, pp. 429-432.

Mullen, P.E., Martin, J.L., Anderson, J.C., Romans, S.E., Herbison, G.P. (1993) childhood sexual abuse and mental health in adult life. *British Journal of Psychiatry*, 162, pp. 721-732.

Mullen, P., Taylor, P.J., Wessely, S. (1995) Psychosis Violence and Crime pp. 327-372. In: Gunn, J., Taylor, P.J. eds. *Forensic Psychiatry. Clinical Legal and Ethical Issues.* Paperback edition. Butterworth Heinemann. London.

Murray, K., Rudge, S., Lack, S. and Dolan, R. (1994) How many high security beds are needed? Implications from an audit of one region's special hospital patients. *Journal of Forensic Psychiatry,* 5, pp. 487- 499.

Mustill, M. (1991) Concluding Reflections pp. 226-227. In: Herbst, K., Gunn, J. eds. *The Mentally Disordered Offender.* Butterworth Heinemann. Oxford.

Naismith, L., Coldwell, J. (1990) A comparison of male admissions to a special hospital 1970-1971 and 1987-1988. *Medicine, Science and the Law,* 30, pp. 301-308.

Newcomb, M.D., Locke, T.F. (2001) Intergenerational cycle of maltreatment: A popular concept obscured by methodological limitations. *Child abuse and Neglect*, 25, pp. 1219-1240.

NHS Executive (1999) HSC 1999/217: *Nurse Midwife and Health visitor Consultants.* London. N.H.S.E.

Niskala, H. (1986) Competencies and Skills required by Nurses working in Forensic Areas.*Western Journal of Nursing Research*, 8 (4), pp. 400 – 413.

NSPCC (2001 URL) http// www.nspcc.org.uk/inform/info_briefing_home.asp

NSPCC (National Society for the Prevention of Cruelty to Children) (1985) *Child Abuse Deaths.* Information briefing No. 5. London. NSPCC.

Oiler Boyd, C. (1983) Philosophical foundations of qualitative research pp. 66-99. In: Munhall, P.L., Oiler Boyd, C. *Nursing Research. A qualitative perspective.* National League for Nursing.

Oliver, J.E. (1993) Intergenerational transmission of child abuse: Rates research and clinical implications. *American Journal of Psychiatry*, 150, pp. 1315-1324.

Owens, D.J., Straus, M.A. (1975) The social structure of violence in childhood and approval of violence as an adult. *Aggressive Behaviour*, 1, p. 195, 196, 210.

Oxford Dictionary (1960) Revised fourth Edition. University press. London.

Oxford Dictionary (1960) Fowler, F.G., Fowler, H.W. 4th edition. Clarendon Press. Oxford.

Parahoo, K. (1997) Questionnaires pp. 246-281. In: Parahoo, K. *Nursing Research. Principles, Process and Issues*. Palgrave Macmillan. Basingstoke. Hampshire.

Parish, C. (2000) Early Consultation. *Nursing Standard*, 14 (35), 17 May, p. 13.

Patton, M. (1980) *Qualitative evaluation methods*. Sage. Newbury. CA.

Peay, J. (1996) Mentally disordered offenders. In: Maguire, M., Morgan, R., Reiner, R. (1996) (Eds.) *The Oxford Handbook of Criminology*, (2nd ed). Clarendon Press. Oxford.

Peckham, C. (1980) Problems in methodology pp. 45-47. In: Lee, C.M. ed. *Child Abuse, a reader and source book*. Open University Press. Milton Keynes.

Peternelj –Taylor, C. (2000) The Role of the Forensic Nurse in Canada. An evolving specialty pp. 192-212. In: Robinson, D., Kettles, A. eds. *Forensic Nursing and Multi-disciplinary care of the Mentally Disordered Offender*. Jessica Kingsley. London.

Playle, J.F. (1995) Humanism and positivism in nursing: constructions and conflicts. *Journal of Advanced Nursing*, 22 (5), pp. 979-984.

Polit, D.F., Hungler, B.P. (1995) *Nursing Research. Principles and Methods*, (5th ed.). J.B. Lippincott. Philadelphia, Pennsylvania.

Popper, K. (1981) The rationality of scientific revolutions pp. 80-106. In: Hacking, I. ed. *Scientific Revolutions*. University Press. Oxford.

Prins, H. (1995) *Will they do it again?* pp. 228-251. In: Prins, H. *Offenders, Deviants or Patients* (2nd ed.). Routledge. New York.

Puri, B.K. (2002) *SPSS in Practice. An illustrated guide* (2nd ed). Arnold. London

Reed, J. (1997) Risk Assessment and Clinical risk Management: the lessons from recent inquiries. *British Journal of Psychiatry*, April, 170, supplement 32, pp. 4-8.

Renvoize, J. (1993) *Innocence destroyed*. Routledge. London.

Ritchie, S. (1985) *Report to the Secretary of State for Social Services concerning the death of Mr. Michael Martin at Broadmoor Hospital on 6th July 1984*. HMSO. London.

Robinson D., Reed, V. (1996) *Measuring Forensic Psychiatric and Mental Health Nursing Interventions. Developments in Nursing and Health Care series 11.* Aldershot. Avesbury.

Robinson. D., Kettles, A. (2000) *Forensic Nursing and Multidisciplinary care of the Mentally Disordered offender.* Jessica Kingsley. London.

Rogers, R., Gillis, J.R.,. Turner, R..E.,. Frise-Smith,T.(1990) The Clinical Presentation of command Hallucination in a Forensic Population. *American Journal of Psychiatry*, 147,(10), pp. 1304-1307.

Rummell, R.M., Hansen, D.J. (1993) Long-term consequences of childhood physical abuse. *Psychological Bulletin*, 114 (1), pp. 68-79.

Rush, F. (1980) *The Best Kept Secret.* Prentice all. New York.

Ryan, G. (1989) Victim to victimiser. *Journal of Interpersonal Violence*, 4, pp. 325-341.

Schon, D. (1983) *The Reflective Practitioner.* Temple Smith. London.

Schon, D. (1987) *Educating the Reflective Practitioner.* Jossey Bass. San Fransisco.

Seers, K., Crichton, N. (2001) Quantitative research. Designs relevant to nursing and health care. *N.T. Research*, Special Issue, Research methodologies, 6 (1), pp. 487-500.

Schwandt, T.A. (1994) Constructivist, interpretivist approaches to human inquiry pp. 118-137. In: Denzin, N.L., Lincoln, Y.S. eds. *Handbook of Qualitative Research.* Sage Publications. London.

Sellars, C., Hollin, C.R., Howells, K. (1993) Mental Illness, Neurological and Organic Disorder, and Criminal Behaviour pp. 71-86. In: Howells, K., Hollin. C.R. eds. *Clinical Approaches to the Mentally Disordered Offender.* John Wiley and Sons. London.

Serin, R.C. (1991) Psychopathy and Violence in Criminals. *Journal of Interpersonal Violence*, 6, pp. 423-431.

Shah, S.A. (1993) Recent research on crime and mental disorder: some implications for programs and policies pp. 303-317. In: Hodgins, S. ed. *Mental Disorder and Crime.* Sage. Newbury Park. CA.

Shaw, J., McKenna, J., Snowden, P., Boyd, C., McMahon, D., Kilshaw, J. (1994) The North West Region; I-clinical features and placement needs of patients detained in special hospitals. *Journal of Forensic Psychiatry*, 5, pp. 93-105.

Shearer, S.L., Peters, C.P., Quaytman, M.S., Ogden, R.L. (1990) Frequency and Correlates of Childhood Sexual and Physical Abuse Histories in Adult Female Borderline Inpatients. *American Journal of Psychiatry*, 147, pp. 214-216.

Singleton, N., Meltzer, H., Gatward, R., cold, J., Deasy, D. (1998) *Psychiatric Morbidity among Prisoners*. Stationary Office. London.

Snowden, P. (1990) Regional secure units and forensic services in England and Wales pp. 1375-1386. In: Bluglass, R., Bowden, P. eds. *Principles and Practice of forensic Psychiatry*. Churchill Livingstone. England.

Snowden, P. (1995) Facilities and Treatment pp.164. In: Chiswick, D., Cope, R. *Seminars in Practical Forensic Psychiatry*. R.C.P. College Seminar Series. R.C.P. London.

Spatz-Widom, C. (1989a) The cycle of violence. *Science*, 244, pp. 160-166.

Spatz-Widom, C. (1989b) Does violence beget violence? A critical examination of the literature. *Psychological Bulletin*, 106(1), pp. 3-28.

Stephen, Heather. (1999) Nurse Consultants will be at the Forefront of Clinical Patient Care. *Nursing Standard*, 13 (27), March 24-30, pp4-5

Storey L., Dale, C. (1999) *Nursing in Secure Environments*. UKCC. London.

Swanson, J.W., Holzer, C.E., Ganja, V.K., Jono, R.T. (1990) Violence and Psychiatric Disorder in the Community: Evidence from the epidemiological catchment area surveys. *Hospital and Community Psychiatry*, 41, pp. 761-770.

Tarbuck, P. (1994) The therapeutic Use of Security. A Model for Forensic Nursing, pp. 552-570. In: Thompson, T., Mathias, P. eds. *Lyttles Mental Health and Disorder* (2nd edn.). Balliere Tindall. London.

Tarbuck, P., Topping Morris, B., Burnard P. (1999) *Forensic Mental Health Nursing. Strategy and implementation*. Whurr. London.

Taylor, P.J. (1993) Schizophrenia and crime. Distinctive patterns in association pp. 63-86. In: Hodgins, S. ed. *Mental disorder and Crime*. Sage. Newbury Park. CA.

Taylor, P.J. (1986) Psychiatric disorder in London's life sentenced offenders. British *Journal of Criminology*, 26, pp. 63-78.

Taylor, P.J., Garety, P., Buchanan, A., Reed, A., Wessely, S., Katarzyna, R., Dunn, G., Grubin, D. (1994) Delusions and Violence pp. 161-183. In: Monahan, J, Steadman, H.J. eds. *Violence and Mental Disorder. Developments in Risk Assessment*. The University of Chicago Press. Chicago.

Taylor, P.J., Maden, A., Jones, D. (1996) Long term Medium Security Hospital Units: a service gap of the 1990's? *Criminal Behaviour and Mental Health*, 6,(3), pp. 213-229.

Taylor, P.J., Leese, M., Williams, D., Butwell, M., R. and Larkin, E. (1998) Mental disorder and violence: a special hospital study. *British Journal of Psychiatry*, 172, pp. 218-226.

Tennet, G., Way, C. (1984 The English special Hospitals – 12-17 year follow up study: a comparison of violent and nonviolent re-offenders and non-offenders. *Medicine Science and Law*, 24, pp.81-91.

United Kingdom Central Council for Nursing Midwifery and Health visiting (UKCC) (1986) *Project 2000. A New Preparation for Practice.* UKCC. London.

Vogeltan, N.D., Wilsnack, S.C., Harris, T.R., Wilsnack, R.W., Wonderlich, S.A., Kristjanson, A.F. (1999) Prevalence and risk factors for childhood sexual abuse in women. National Survey Findings. *Child Abuse and Neglect*, 23(6), pp. 579-592.

Wallace, C., Mullen, P., Burgess, P., Palmer, S., Ruschena, D., Browne, C. (1998) Serious criminal offending and mental disorder. *British Journal of Psychiatry*, 172, pp. 477-484.

Walsh, B.W., Rosen, P.M. (1988) *Self-Mutilation: Theory research and treatment.* Guilford. New York.

Weeks, R., Spatz-Widom, C. (1998) Self-reports of early childhood victimisation among incarcerated adult male felons. *Journal of Interpersonal Violence*, 13(3), pp.346-361.

Weiler, B.L., Widom, C.S. (1996) Psychopathy and violent behaviour in abused and neglected young adults. *Criminal Behaviour and Mental Health*, 6, pp. 253-271.

Wessely, S., Taylor, P.J. (1991) Madness and Crime. Criminology versus Psychiatry. *Criminal Justice and Mental Health*, 1, pp. 193-228.

Wessely, S.C., Castle, D., Douglas, A.J., Taylor,P.J. (1994) The criminal careers of incident cases of schizophrenia. *Psychological Medicine*, 24,(2) pp. 483-502.

Wessely, S. (1997) The epidemiology of crime, violence and schizophrenia. *British Journal of Psychiatry*, April, 170, supplement 32.

West, M., Abolins, D. (2001) Dealing with hostility pp. 42-72. In: McClelland, N., Humphreys, M., Conlon, L., Hillis, T. eds. *Forensic Nursing and Mental disorder in Clinical Practice.* Butterworth Heinemann. Oxford.

White, E., Brooker, C. (1997) Survey methodology and the issue of response rate. The case example of a community mental health nursing census. *N.T. Research*, 2 (3), pp. 164-174.

Widiger, T.A., Trull, T.J. (1994) Personality disorders and violence pp. 203-226. In: Monahan, J, Steadman, H.J. eds. *Violence and Mental Disorder. Developments in risk Assessment.* The University of Chicago Press. Chicago.

Wilshaw, G. (1999) Perspectives on surviving childhood sexual abuse. *Journal of Advanced Nursing*, 30(2), pp. 303-309.

Wilson, D.L. (1996) Self Paced Studies. *Chronicle of Higher Education*, XLII (21), (Feb 2), A19-A20.

Wolfgang, M.E., Ferracuti, F. (1967) *The subculture of violence. Toward an integrated theory in criminology*. Tavistock. London.

World Health Organisation (1992) *International Classification of Diseases and Causes of Death* (10^{th} edn.). Geneva, WHO.

Wyatt, G.E., Powell, G.J. (1988) Identifying effects of child sexual abuse: An overview pp. 11-19. In: Wyatt, G.E., Powell, G.J. eds. *Lasting effects of child sexual abuse*. Sage. CA.

APPENDIX FIVE

Dear colleague,

I have been engaged in study over the last 3 years examining the prevalence of abuse suffered in childhood and adolescence, by in-patients of medium secure hospital settings. Allied to this I am also reviewing clinical decision making amongst nursing staff in such units.

I would therefore be grateful if you would take the time to complete the enclosed questionnaire and rating schedule related to the above research.

There is official approval for me to undertake this work from the ethics committees of the Hospital Trusts concerned. The case vignettes detailing abuse history, as well as your identity will remain anonymous, there will be no way of identifying you in this research and no names have been requested or will be included in the final report.

Following completion of the brief questionnaire (page 1), can you please read through each Case History. Using the 'Severity of Maltreatment' guide enclosed (page 2) can you rate the severity of maltreatment suffered, using the case information provided. Please use the numbered rating system provided on each sheet. Please provide a rationale for your rating, i.e. why you have rated the case in the way you have, including what knowledge or information contributed to your clinical decision. Following this please answer the additional question regarding 'experience' at the foot of each 'case history' page.

If you require more information with regard to completion of the document please do not hesitate to contact me at the following address:

Please return your completed questionnaire to the research contact person designated within your unit.

Thank you.

Norman McClelland
Associate Director Clinical Development
Tees and North East Yorkshire NHS Trust
Flatts lane Centre
Normanby
Middlesbrough

Tel: 01642 283993 or 07887994585

Appendix 5

Please provide the following information

1. Gender: (Please tick the appropriate box)

MALE	FEMALE

2. Age: (Please tick the appropriate box)

21 – less than 30 years	
30 – less than 40 years	
40 years and over	

3. Year of qualifying as a mental health nurse

4. Length of qualified nursing experience:

(Please tick the appropriate box)

0 – less than 5 years	
5 – less than 10 years	
10 years and over	

5. Your registration qualification:

(Please tick the appropriate box)

Enrolled Nurse (EN)	
Registered Mental health Nurse (RMN)	
RMN - Diploma	
RMN – Advanced Diploma	
RMN - Degree	

6. Post Registration Qualifications:

(Please include formal post registration qualifications such as ENB courses, Degrees, Diplomas, Masters or Doctorates including the title of the qualification i.e. ENB 770 Nursing in Controlled Environments, or BSc Nursing Studies etc.)

QUALIFICATIONS

Appendix 5

Severity of Maltreatment Classification

Less Severe (Please rate as 1)

Minor incidents of an infrequent nature with little or no long term damage either physical, sexual or psychological.
Physical; e.g. injuries confined in area and limited to superficial tissue, including cases of light scratch marks, small slight bruising, minute burns and small welts.
Sexual; e.g. inappropriate sexual touching, invitations and/or exhibitionism.
Emotional; e.g. occasional verbal assaults, denigration, humiliation, scapegoating, confusing atmosphere.
Neglect; e.g. occasional withholding of love and affection, weight parallel to or slightly below third centile with no organic cause.

Moderately Severe (Please rate as 2)

More frequent incidents and/or of a more serious nature, but unlikely to be life threatening or have potentially severe long term effects.
Physical; e.g. surface injuries of an extensive or more serious nature and small subcutaneous injuries including cases of extensive bruising, large welts, lacerations, small haematomas and minor burns.
Sexual; e.g. Non-penetrative sexual interaction of an indecent or inappropriate nature; such as fondling, masturbation and digital penetration.
Emotional; e.g. frequent verbal assaults, denigration and humiliation, occasional rejection.
Neglect; e.g. frequent withholding of love and affection, non-organic failure to gain weight.

Very Severe (Please rate as 3)

Ongoing or very frequent maltreatment and/or less frequent incidents with potentially very severe physical or psychological harm.
Physical e.g. all long and deep tissue injuries and broken bones (including fractures, dislocations, subdural haematomas, serious burns and damage to internal organs).
Sexual; e.g. sexual interaction involving attempted or actual oral, anal or vaginal penetration.
Emotional; e.g. frequent rejection, occasional withholding of food and drink, enforced isolation and restriction of movement.
Neglect; e.g. frequent unavailability of parent, guardian or spouse, non-organic failure to thrive.

Life Threatening (Please rate as 4)

Long term or severe psychological and physical harm that results in life threatening situations (including perpetrators failing to seek help in time or victims harming themselves).
Physical; e.g. deliberate or persistent injuries, which have the potential of victim death or near death.
Sexual; e.g. incest, coerced or forced penetration (oral, anal or vaginal) over a prolonged period.
Emotional; e.g. persistent rejection, failure to nurture, frequent withholding of food and drink, enforced isolation and restriction of movement.
Neglect; e.g. persistent unavailability of parent, guardian or spouse, non-organic failure to maintain weight.

From; Kevin Browne and Martin Herbert (1997)
Preventing Family Violence
Chapter One; Forms of family violence and levels of prevention p10-11
John Wiley and Sons: Chichester

Appendix 5

Case History 3

Sexually abused aged 9 yrs, twin sister also sexually abused at the time. Case 3s Mother gave up care of Case 3 when Case 3 was 15 yrs old. Case 3 has indicated being scared of Mother because of aggression. Case 3 has consistently reported episodes of sexual abuse as a child. Local authority records indicate evidence of emotional and physical abuse of Case 3. Case 3 self reports sexual abuse as a child by a neighbour, and by an older man when aged 8 or 9; "He kissed me and interfered with me down below, he did the same thing to my sister, and a friend of mine who was aged 6".

Please rate the severity of maltreatment experienced in this case:

(please tick as appropriate)

Less severe	1	
Moderately severe	2	
Very severe	3	
Life threatening	4	

Please provide a rationale for your rating i.e. why you have rated the case in the way you have?, what knowledge or information contributed to your clinical decision?

To what extent has your experience prepared you to make a competent judgement?

(please tick as appropriate)

A very large extent	A large extent	Neither very large nor no extent	A little extent	No extent

Appendix 5

Case History 5

Hit whilst at home by Aunt who was in residence at Case 5s home. This happened until case 5 was aged 17, when case 5 retaliated. Case 5 self reports that Mother lived at the end of the road to where case 5 lived with Grandparents. The Grandparents prevented case 5 from visiting the Mother, and the Mother from visiting case 5. The parents had separated when case 5 was aged three yrs. The Grandparents told case 5 'horrible' stories about the Mother. Case 5s Grandparents and Aunt 'appear to have been fairly physically abusive toward case 5'.

Please rate the severity of maltreatment experienced in this case:

(please tick as appropriate)

Less severe	1	
Moderately severe	2	
Very severe	3	
Life threatening	4	

Please provide a rationale for your rating i.e. why you have rated the case in the way you have?, what knowledge or information contributed to your clinical decision?

To what extent has your experience prepared you to make a competent judgement?

(please tick as appropriate)

A very large extent	A large extent	Neither very large nor no extent	A little extent	No extent

Appendix 5

Case History 7

Self reports childhood as 'violent'. Parents often physically fought with each other. Father would hit case 7. Self reports that at age 14 was kicked out of school for disruptive behaviour, it is reported that case 7 'sniffed glue' until age 16. Self reports that father was physically abusive and a heavy drinker, case 7 recalls being punched and spat at and told that; 'you are a waste of time'. Case 7's over-riding memory of childhood is of parental arguments.

Please rate the severity of maltreatment experienced in this case:

(please tick as appropriate)

Less severe	1	
Moderately severe	2	
Very severe	3	
Life threatening	4	

Please provide a rationale for your rating i.e. why you have rated the case in the way you have?, what knowledge or information contributed to your clinical decision?

To what extent has your experience prepared you to make a competent judgement?

(please tick as appropriate)

A very large extent	A large extent	Neither very large nor no extent	A little extent	No extent

Appendix 5

Case history 11

Case 11 reports a life characterized by insecurity and instability. Case 11's father drank heavily, was a stern disciplinarian, and is reported to have been often physically violent toward case 11 and siblings. Father was convicted of incest with a female sibling of case 11, this is reported to have been disruptive to case 11's life. Case 11's mother drank alcohol to excess, and case 11 developed a stammer and nocturnal enuresis, truanting from school and becoming involved in offending. Case 11 followed siblings into voluntary care when aged 10 (reportedly beyond control). Case 11 was assessed by a young persons secure unit because of fire setting behaviour as a child. Case 11 self reports that mother was 'always swearing', and that she ' had been violent since I was small'. Case 11 recalls being hit 6 times or more with a belt when aged 4 or 5, and being left in urine soaked sheets for days at a time, his mother drinking during the day. Both parents used to burn case 11's fingers to prevent case 11 playing with matches. Case 11 reports seeing father punch mother, and often being locked in a room with siblings not being allowed to talk or read. Case 11 reports liking school because it took case 11 away from home.

Please rate the severity of maltreatment experienced in this case:

(please tick as appropriate)

Less severe	1	
Moderately severe	2	
Very severe	3	
Life threatening	4	

Please provide a rationale for your rating i.e. why you have rated the case in the way you have?, what knowledge or information contributed to your clinical decision?

To what extent has your experience prepared you to make a competent judgement?

(please tick as appropriate)

A very large extent	A large extent	Neither very large nor no extent	A little extent	No extent

Appendix 5

Case History 18

Delinquent behaviour reported since the age of 12. Case 18 has reported that father was a drunkard. Case 18 has a history of urinary tract infection from childhood. Case 18 self reports being seen by a doctor as a child after 2 incidents of sexual abuse from a male friend of the family who lived nearby. Case 18 also reports that mother discovered a female babysitter masturbating herself and case 18, when case 18 was 4 years old.

Please rate the severity of maltreatment experienced in this case:

(please tick as appropriate)

Less severe	1	
Moderately severe	2	
Very severe	3	
Life threatening	4	

Please provide a rationale for your rating i.e. why you have rated the case in the way you have?, what knowledge or information contributed to your clinical decision?

To what extent has your experience prepared you to make a competent judgement?

(please tick as appropriate)

A very large extent	A large extent	Neither very large nor no extent	A little extent	No extent

Appendix 5

Case History 23

Case 23 self reports that parents argued considerably, and that father was 'aggressive but never violent'. Case 23 self reports that when aged 14, whilst in a cinema, a man fondled case 23 through case 23's clothing. Case 23 allowed this to continue for ten minutes, and then walked away.

Please rate the severity of maltreatment experienced in this case:

(please tick as appropriate)

Less severe	1	
Moderately severe	2	
Very severe	3	
Life threatening	4	

Please provide a rationale for your rating i.e. why you have rated the case in the way you have?, what knowledge or information contributed to your clinical decision?

To what extent has your experience prepared you to make a competent judgement?

(please tick as appropriate)

A very large extent	A large extent	Neither very large nor no extent	A little extent	No extent

Appendix 5

Case History 26

At age 7 case 26 was subjected to sexual abuse by a man who later received a prison sentence. Case 26 has reported flashbacks and states that; ' I still see the man's face', at age 13 case 26 was reported to be abusing solvents and cannabis.

Please rate the severity of maltreatment experienced in this case:

(please tick as appropriate)

Less severe	1	
Moderately severe	2	
Very severe	3	
Life threatening	4	

Please provide a rationale for your rating i.e. why you have rated the case in the way you have?, what knowledge or information contributed to your clinical decision?

To what extent has your experience prepared you to make a competent judgement?

(please tick as appropriate)

A very large extent	A large extent	Neither very large nor no extent	A little extent	No extent

Appendix 5

Case History 29

At age 11 case 29 was bullied at school and subjected to homosexual abuse. As a weekly boarder at a school case 29 was asked to masturbate boys and provide oral sex. Case 29 has stated; 'I used to dread going back after weekends'.

Please rate the severity of maltreatment experienced in this case:

(please tick as appropriate)

Less severe	1	
Moderately severe	2	
Very severe	3	
Life threatening	4	

Please provide a rationale for your rating i.e. why you have rated the case in the way you have?, what knowledge or information contributed to your clinical decision?

To what extent has your experience prepared you to make a competent judgement?

(please tick as appropriate)

A very large extent	A large extent	Neither very large nor no extent	A little extent	No extent

Appendix 5

Case History 33

Case 33's father was a catholic priest who had left the priesthood. There are reports that case 33's father used to sexually abuse the sister of case 33 when case 33 was in the same room. Case 33's family report that the 'father was close to case 33 in a way which was beyond normal'. Case 33's sister, whilst resident in a secure unit, alleges that both her father and case 33 (when a child) abused her sexually. Case 33 denies such abuse experienced or given.

Please rate the severity of maltreatment experienced in this case:

(please tick as appropriate)

Less severe	1	
Moderately severe	2	
Very severe	3	
Life threatening	4	

Please provide a rationale for your rating i.e. why you have rated the case in the way you have?, what knowledge or information contributed to your clinical decision?

To what extent has your experience prepared you to make a competent judgement?

(please tick as appropriate)

A very large extent	A large extent	Neither very large nor no extent	A little extent	No extent

Appendix 5

Case History 35

At age 15 years case 35 reported to a teacher that sexual abuse had occurred within the family, and that a family member (sibling) had been having full intercourse with case 35 over the previous 3 years. Case 35 had reported assaults from the father of the house, and had requested a place of safety. At this time a brief admission to a children's home occurred. Case 35's name had been placed on the 'at risk register' when case 35 was a child. As a child case 35 was taken to Pakistan and on return reported prolonged sexual abuse by a sibling. Following a hospital admission (when an adult) case 35 was exhibiting temper outbursts and property destruction and scratching wrists, blaming the lack of help received in dealing with 'past trauma'. Following a further referral to a specialist hospital the referring doctors view was that case 35 had emotional and behavioural disturbances consistent with past sexual abuse. Later reports indicate that case 35 described 'flashbacks of abuse' saying that; 'voices are instructing me to stab a child'. An entry in the case notes refers to; 'case 35 being subject to prolonged and serious sexual abuse during adolescence. Case 35 self reports that case 35 had encouraged the sibling in the sexual abuse from the age of 12. Case 35 has also alleged mental cruelty, constant taunting and ridicule from this sibling. Case 35's parents reacted in disbelief at this information. Case 35 reports that the father's reaction was to further physically and mentally abuse case 35. Hospital noted report that this latter abuse took place over considerable time involving repeated acts of rape. Case 35 self reports a rape from father when case 35 was aged 10 years.

Please rate the severity of maltreatment experienced in this case:

(please tick as appropriate)

Less severe	1	
Moderately severe	2	
Very severe	3	
Life threatening	4	

Please provide a rationale for your rating i.e. why you have rated the case in the way you have?, what knowledge or information contributed to your clinical decision?

Appendix 5

To what extent has your experience prepared you to make a competent judgement?

(please tick as appropriate)

A very large extent	A large extent	Neither very large nor no extent	A little extent	No extent

Appendix 5

Case History 40

Case 40 described the father of the household as a heavy drinker, who was cruel to case 40, the mother and pets of the household. The father would be violent to his wife and children and had killed case 40's pet dog. The father is reported to have thrown cats onto the road to be run over, and to have drowned them. On one occasion the father threw boiling water over case 40, requiring case 40 (who was a child at this time) to attend casualty. Case 40 left home aged 16 due to problems with father.

Please rate the severity of maltreatment experienced in this case:

(please tick as appropriate)

Less severe	1	
Moderately severe	2	
Very severe	3	
Life threatening	4	

Please provide a rationale for your rating i.e. why you have rated the case in the way you have?, what knowledge or information contributed to your clinical decision?

To what extent has your experience prepared you to make a competent judgement?

(please tick as appropriate)

A very large extent	A large extent	Neither very large nor no extent	A little extent	No extent

Appendix 5

Case History 47

Reported to have developed large bump on side of head at age 3 days, which remained until case 47 was 18months old. Many developmental milestones occurred in a delayed manner, case 47 experienced problems requiring involvement with a speech therapist from age 3, and further being seen by an educational psychologist during these sessions. Whilst at school case 47 was deemed to be below average ability. Case 47 alleged physical and sexual abuse from age 15 by the mathematics teacher at school. Following inquiries these allegations were deemed to be unfounded. Case 47 stated that the teacher hit case 47, and there are regular reports of bruising at this time. Case 47 also alleged that the teacher inappropriately touched case 47. Case 47's background is 'characterised by parental divorce, physical abuse and possible sexual abuse, alcohol and substance misuse and poor relations with family members'. In case 47's history there are; 'disturbed family dynamics, many allegations of physical and possible sexual abuse by an older sibling'. Case 47 has self reported physical abuse from one of the elder siblings.

Please rate the severity of maltreatment experienced in this case:

(please tick as appropriate)

Less severe	1	
Moderately severe	2	
Very severe	3	
Life threatening	4	

Please provide a rationale for your rating i.e. why you have rated the case in the way you have?, what knowledge or information contributed to your clinical decision?

To what extent has your experience prepared you to make a competent judgement?

(please tick as appropriate)

A very large extent	A large extent	Neither very large nor no extent	A little extent	No extent

Appendix 5

Case History 51

Both case 51's parents are reported to have significant history of mental illness, and to be significantly aggressive, both drinking heavily. The mother left the family home when case 51 was 10 years of age. Case 51's early life was overshadowed by the acrimonious relationship between the parents, the father's leg being broken on one occasion by the mother (with a sewing machine). It is also reported that case 51 was subject to physical abuse by both parents, case 51's father being charged with sexual abuse, but was found not guilty at trial. At age 12 case 51 spent 3 months in the care of the local authority, exhibiting a range of disturbed behaviours, glue sniffing, self mutilation and absconding. Case 51 alleged sexual abuse by father during teenage years, and many relationships from age 14 years, one being with an older woman when in residential care. At age 14 years it is reported that case 51 had a relationship with a same sex member of staff in a home. Case 51 reports that the mother carried out regular physical punishments, knocking case 51 'out' on one occasion using a poker to the head. It is reported that case 51 witnessed many violent outbursts within the family, and experienced many assaults by both parents. Many inappropriate relationships with carers occurred when case 51 was resident in care homes during childhood.

Please rate the severity of maltreatment experienced in this case:

(please tick as appropriate)

Less severe	1	
Moderately severe	2	
Very severe	3	
Life threatening	4	

Please provide a rationale for your rating i.e. why you have rated the case in the way you have?, what knowledge or information contributed to your clinical decision?

Appendix 5

To what extent has your experience prepared you to make a competent judgement?

(please tick as appropriate)

A very large extent	A large extent	Neither very large nor no extent	A little extent	No extent

Appendix 5

Case History 54

During early teenage years case 54 was sexually abused by older boys. Case 54 is reluctant to talk about this abuse. The case notes indicate an incident of inappropriate sexual contact occurring between case 54 and sibling in childhood. Case 54 reports being affected by this incident, and being in confusion concerning sexuality. Whilst at comprehensive school sexual abuse by older boys occurred, many older boys on a regular basis. Case 54 unable to talk about this, but feeling 'humiliated and quite bad'. These older boys are reported to have been physically abusive toward case 54 also.

Please rate the severity of maltreatment experienced in this case:

(please tick as appropriate)

Less severe	1	
Moderately severe	2	
Very severe	3	
Life threatening	4	

Please provide a rationale for your rating i.e. why you have rated the case in the way you have?, what knowledge or information contributed to your clinical decision?

To what extent has your experience prepared you to make a competent judgement?

(please tick as appropriate)

A very large extent	A large extent	Neither very large nor no extent	A little extent	No extent

Appendix 5

Case History 58

The mother of case 58 reports the father as violent and cruel, frequently assaulting case 58. The father was a heavy drinker, drug taker and gambler. The parents' divorce related to a petition from the mother for violence and cruelty. Case 58 spent some childhood time in care. All case 58's siblings have at times been in care due to unsatisfactory home circumstances. As a child case 58 was reported as underweight, apathetic and responding to human contact by crying when in nursery. The parents were reported for cruelty to the RSPCC, for cruelty to one of case 58's siblings. At one year case 58 was found by a social worker in a cot, sodden, with no covers and playing with own excrement. Case 58 displayed a lack of response to affection and slow development. At age 18 months case 58 was abandoned in a DHSS office, when taken home no food could be found in the home. Abandoned again (at 2 years) with 2 other siblings at an aunts house, and taken in to care. On case 58's fifth birthday all the children were again taken into care, but were quickly returned home on trial leave. Six month later all taken into care again after marks and bruising were found on a sibling of case 58. Father subsequently charged with GBH received a 2 year conditional discharge. Siblings returned home but case 58 remained in care for further 2 years following the charge on father. Case 58 was returned to the mother after she settled with a new boyfriend, and returned to care when this relationship ended. Case 58 later alleged sexual abuse from this man. Over 15 yeas of childhood case 58 experienced 15 different placements a total of 33 months at home. Case 58 claims to have had a relationship at age 10 years, and sexual intercourse at age 12 years with 'consent'. Case notes record that as a baby case 58 experienced ' gross physical neglect, desertion by parents, and possible childhood sexual abuse from a cohabitee'.

Please rate the severity of maltreatment experienced in this case:

(please tick as appropriate)

Less severe	1	
Moderately severe	2	
Very severe	3	
Life threatening	4	

Please provide a rationale for your rating i.e. why you have rated the case in the way you have?, what knowledge or information contributed to your clinical decision?

Appendix 5

To what extent has your experience prepared you to make a competent judgement?

(please tick as appropriate)

A very large extent	A large extent	Neither very large nor no extent	A little extent	No extent

Appendix 5

Case History 64

Case 64 self reports difficulty with father as a child. Self reports first sexual contact at 13 years with two 17year old babysitters, having sexual intercourse with both after they got into case 64's bed. Self reports that the babysitters were in control and case 64 was confused, but does not feel this to be an abusive experience. Another full sexual, 'consenting' relationship occurred with a same age partner when case 64 was 14 years of age.

Please rate the severity of maltreatment experienced in this case:

(please tick as appropriate)

Less severe	1	
Moderately severe	2	
Very severe	3	
Life threatening	4	

Please provide a rationale for your rating i.e. why you have rated the case in the way you have?, what knowledge or information contributed to your clinical decision?

To what extent has your experience prepared you to make a competent judgement?

(please tick as appropriate)

A very large extent	A large extent	Neither very large nor no extent	A little extent	No extent

Appendix 5

Case History 72

Case 72's father was teetotal, never smoked, insisting on the same for his children. Father reportedly hit the children if they would not go to church, not allowing them to read comics or watch television. Case 72 reports an unhappy childhood ' always being beaten by father'.

Please rate the severity of maltreatment experienced in this case:

(please tick as appropriate)

Less severe	1	
Moderately severe	2	
Very severe	3	
Life threatening	4	

Please provide a rationale for your rating i.e. why you have rated the case in the way you have?, what knowledge or information contributed to your clinical decision?

To what extent has your experience prepared you to make a competent judgement?

(please tick as appropriate)

A very large extent	A large extent	Neither very large nor no extent	A little extent	No extent

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Appendix 5

Case History 92

At age 3 years the local authority was concerned about the lack of stimulation in case 92's home environment, suspecting both physical and sexual abuse. Records indicate that case 92 suffered epileptic seizures at age three, was withdrawn in school and benefiting from one to one counselling at a very young age. At age 14 records indicate a turbulent life, with parents as violent to each other. Case 92 was subject to bullying and ill treatment while at school, and alleged sexual abuse by father at age 15. At this time the local authority obtained an interim care order and case 92 was placed in a residential project. Case 92 remembers being held down by mother for father to beat case 92. Case 92 has further disclosed that sexual abuse occurred from age 5 onward, the extent of this abuse being unclear.

Please rate the severity of maltreatment experienced in this case:

(please tick as appropriate)

Less severe	1	
Moderately severe	2	
Very severe	3	
Life threatening	4	

Please provide a rationale for your rating i.e. why you have rated the case in the way you have?, what knowledge or information contributed to your clinical decision?

To what extent has your experience prepared you to make a competent judgement?

(please tick as appropriate)

A very large extent	A large extent	Neither very large nor no extent	A little extent	No extent

Appendix 5

Case History 96

At a young age case 96's mother went to America to secure work. She returned 2 years later to discover that her husband had failed to care for case 96 and siblings properly. Apparently the father had been providing very little food, not washing or cleaning for the children, and staying away from the home for days at a time.

Please rate the severity of maltreatment experienced in this case:

(please tick as appropriate)

Less severe	1	
Moderately severe	2	
Very severe	3	
Life threatening	4	

Please provide a rationale for your rating i.e. why you have rated the case in the way you have?, what knowledge or information contributed to your clinical decision?

To what extent has your experience prepared you to make a competent judgement?

(please tick as appropriate)

A very large extent	A large extent	Neither very large nor no extent	A little extent	No extent

Appendix 5

Case history 99

Case 99's teachers had expressed concerns of case 99 being bullied at school. A breakdown between case 99 and mother resulted in case 99's name being placed on the child protection register. At age 15 years case 99 became pregnant giving birth to twins. Substance abuse is in evidence from age 11 years when case 99 was excluded from school for drunkenness and use of cannabis.

Please rate the severity of maltreatment experienced in this case:

(please tick as appropriate)

Less severe	1	
Moderately severe	2	
Very severe	3	
Life threatening	4	

Please provide a rationale for your rating i.e. why you have rated the case in the way you have?, what knowledge or information contributed to your clinical decision?

To what extent has your experience prepared you to make a competent judgement?

(please tick as appropriate)

A very large extent	A large extent	Neither very large nor no extent	A little extent	No extent

Appendix 5

Case History 102

Self reports childhood as unhappy and unsettled. Case 102 attended a clinic until aged 11 being boarded there due to 'behavioural disturbances'. A child guidance clinic had referred case 102 to this clinic. Case 102 was allegedly 'repeatedly sexually assaulted at this boarding school between ages 12-13 by a male resident'. At this time case 102 had repeatedly requested to leave this school and was later transferred.

Please rate the severity of maltreatment experienced in this case:

(please tick as appropriate)

Less severe	1	
Moderately severe	2	
Very severe	3	
Life threatening	4	

Please provide a rationale for your rating i.e. why you have rated the case in the way you have?, what knowledge or information contributed to your clinical decision?

To what extent has your experience prepared you to make a competent judgement?

(please tick as appropriate)

A very large extent	A large extent	Neither very large nor no extent	A little extent	No extent

Appendix 5

Case History 108

Self reports that parents 'argued an awful lot' when growing up. Case 108 further reports that an occasion was witnessed when aged 7, when mother tried to stab father with a knife. Case 108 recalls many unhappy memories as a child and many arguments between parents and 'lots of bullying at school'.

Please rate the severity of maltreatment experienced in this case:

(please tick as appropriate)

Less severe	1	
Moderately severe	2	
Very severe	3	
Life threatening	4	

Please provide a rationale for your rating i.e. why you have rated the case in the way you have?, what knowledge or information contributed to your clinical decision?

To what extent has your experience prepared you to make a competent judgement?

(please tick as appropriate)

A very large extent	A large extent	Neither very large nor no extent	A little extent	No extent

Appendix 5

Case History 114

Case 114 self reports a family life of 'considerable tension and conflict'. The presence of domestic violence when case 114 was a young child is mentioned frequently within the case notes.

Please rate the severity of maltreatment experienced in this case:

(please tick as appropriate)

Less severe	1	
Moderately severe	2	
Very severe	3	
Life threatening	4	

Please provide a rationale for your rating i.e. why you have rated the case in the way you have?, what knowledge or information contributed to your clinical decision?

To what extent has your experience prepared you to make a competent judgement?

(please tick as appropriate)

A very large extent	A large extent	Neither very large nor no extent	A little extent	No extent

APPENDIX SIX

QUESTIONNNAIRE
for Clinicians based in Medium Secure Units

Please indicate the degree to which you agree or disagree with the following statements (with a tick)

Please provide a rationale for your decision

Key: SA= Strongly Agree, A= Agree, N = Neither Agree Nor Disagree, D= Disagree, SD = Strongly Disagree.

Please return your completed questionnaire to the identified research contact within your unit. Thank you

Norman McClelland
Senior Nurse
Education & Practice Development
Tees & North East Yorkshire NHS Trust

Please indicate your answers to short responses with a tick.

1) Adults who recognise and reject abuse suffered in their own childhood are more likely to break patterns of abuse behaviour in which they are involved.

Please provide a tick in the appropriate box;

S.A.	A.	N	D	S.D.

Please provide rationale for your answer.

2) Research into the area of abuse for childhood / adolescence is weak because of the many methodological problems associated with such work.

S.A.	A.	N.	D.	S.D.

Please provide rationale for your answer.

3) Sexually abused males are more likely to engage in violent behaviours in later life than sexually abused females.

S.A.	A.	N.	D.	S.D.

Please provide rationale for your answer.

4) Evidence of abuse in childhood or adolescence is a strong predictor of adult violent behaviour.

S.A.	A.	N.	D.	S.D.

Please provide rationale for your answer.

5) Schizophrenics are more likely to commit violent offences than other disordered groups.

S.A.	A.	N.	D.	S. D.

Please provide rationale for your answer.

6) Children are best brought up in their natural families.

S.A.	A.	N.	D.	S.D.

Please provide rationale for your answer

7) Violence is pre-determined by biological causes, (such as genetic predisposition, or head injury), before the age of 14.

S.A.	A.	N.	D.	S.D.

Please provide rationale for your answer.

8) The severity of abuse suffered in childhood/ adolescence is associated with the level of violence exhibited by adults who engage in such behaviour.

S.A.	A.	N.	D.	S.D.

Please provide rationale for your answer

9) Severe maltreatment in childhood/ adolescence will irretrievably damage an individuals personality.

S.A	A.	N.	D.	S.D.

Please provide rationale for your answer

10) The high proportion of mental disorder in offender populations (as opposed to the general population) is evidence of a causal link between mental illness and criminality.

S.A.	A.	N.	D.	S. D.

Please provide rationale for your answer.

11) Mental disorder/distress is no more prevalent in Adults who have been abused in childhood / adolescence than in adults who have not been abused.

S.A.	A.	N.	D.	S.D.

Please provide rationale for your answer.

12) Clinicians can play a part in planning interventions to prevent recurrence of abusive child rearing patterns.

S.A.	A.	N.	D.	S.D.

Please provide rationale for your answer

13) It is likely that three quarters, or more, of those abused in childhood or adolescence, will go on to violently offend.

S.A.	A.	N.	D.	S.D.

Please provide rationale for your answer.

14) There is a disproportionate amount of research conducted in favour of post-abuse treatment of families and children, as opposed to research on prevention.

S.A.	A.	N.	D.	S.D.

Please provide rationale for your answer

15) Many parents exhibit violence as a continuum of behaviour they themselves have experienced.

S.A.	A.	N.	D.	S.D.

Please provide rationale for your answer.

Can you please provide the following information;

1) **Please indicate your profession –**

2) **Please indicate approximate years of service-**

3) **In your career have you ever been engaged in therapeutic work with an individual who has been abused in any one of the following ways: sexual, psychological or physical**

Yes: ***No:***

4) **Have you been directly involved in a violent incident in the work place in the past twelve months-**

Yes: ***No:***

Please tick as appropriate

5) **Please indicate if you are male or female-**

Male ***Female***

Thank you for your help and co-operation in completing this Questionnaire.

APPENDIX SEVEN

MEDIUM SECURE UNIT: _____

NAME: _____ **(CODE NUMBER)**

AGE/DOB: _____

SEX:_____ **SECTION:**_____

MARITAL STATUS: _____ **ETHNIC ORIGIN:**_____

DIAGNOSIS:_____

INDEX OFFENCE:

PREVIOUS HISTORY / EVIDENCE OF ABUSE (ANONYMISED):

APPENDIX EIGHT

Text cut off in original

Ealing, Hammersmith and Fulham NHS
Mental Health NHS Trust

Mr Norman McClelland,
Senior Nurse - Education/Practice Development,
West Lane Hospital,
Acklam Road,
Middlesbrough
TS5 4EE

Our Ref: SB/99/58 **15th December 1999**

Dear Mr McClelland,

Re: Protocol: Cycles of abuse, the intergenerational transmission of abuse:

The Ethics Committee considered your submission in full at their meeting on Friday, 26th November 1999 **and had no ethical concerns with the study.** However, they would like you to address the following point:

- You must identify a link person within the Ealing, Hammersmith & Fulham Mental Health Trust with whom you can collaborate with, in order to facilitate the project's R&D registration;

Subject to the above proviso, I will be happy to confirm the Committee's approval for the study to proceed. The following personnel represented the Committee:

Dr I Treasaden	-	Consultant Forensic Psychiatrist (chair)
Ms T Hilton	-	Principal Pharmacist
Mrs N Law	-	Lay Member
Dr M Leung	-	Clinical Psychologist
Dr M Maier	-	Consultant/Senior Lecturer
Mr M Petrovic	-	Senior Administrator
Dr D Taylor	-	Consultant in Old Age Psychiatry

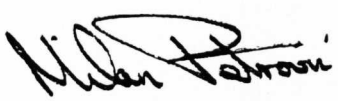
In line with this Committee's Standard Operating Procedures, the following are requested:

- The need to comply, throughout the conduct of the study, with good clinical research practice standards;
- To enable the Committee to receive feedback of research approved, you are requested to provide six-monthly reviews. Where this is not provided, the Committee reserve the right to suspend approval of the protocol;
- The results of the research should be sent to the Chairman of the Committee, if necessary in draft form, pending a copy of the completed final report/publication, which will be made available in the Medical Library;
- Further research projects submitted to the Ethical Committee by researchers who fail to comply with these conditions will not be approved;
- If there are any further changes to the Protocol, these must be notified to the Committee for approval.

May I take this opportunity to wish you well in your study and to offer my apologies for the delay in responding to you.

With kind regards,

Yours Sincerely,



Dr Ian Treasaden,
Ethics Committee Chairman

DIRECTORATE OF NURSING DEVELOPMENT

SOUTH TEES
ACUTE HOSPITALS NHS TRUST

MIDDLESBROUGH GENERAL HOSPITAL
Ayresome Green Lane
Middlesbrough
Cleveland TS5 5AZ
Telephone: (01642) 854344/854438
Fax: (01642) 854438
email: b.footitt@onyxnet.co.uk

JD/VJS

28 October 1999

Mr N McClelland
Associate Director of Nursing
Education Practice Development
West Lane Hospital

Dear Norman

Cycles of abuse: "The intergenerational transmission of abuse in clinical samples and associations with violent offending."

Thank you for the above submission to the Nurses and Paramedical Research Advisory Group on 7 October 1999.

Following review of your proposal, the committee is pleased to advise you that your proposal has been approved and that you may go ahead with your study.

We wish you every success with your project and look forward to seeing your final report.

Yours sincerely

Dr J Drury
Acting Chair - Nurses and Paramedical Research Advisory Group
Chief of Pathology

TEXT BOUND INTO

THE SPINE

Iechyd Morgannwg Health

LOCAL RESEARCH ETHICS COMMITTEE
Chairman : Mr Scott Pegler - Drug Information Pharmacist
Secretary : Mrs Nicola John - Consultant in Pharmaceutical Public Health
Administrator : Miss Lawmary Champion
Direct Telephone : 01792 - 607416

41 High Street, Swansea SA1 1LT
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Your ref / Eich cyf:

Our ref / Ein cyf:

99.134
Enquiries to / Holwch:

Direct Dial No. / Rif Deialu Union:
Lawmary Champion
Extension 7416
Direct line 607416

Norman McClelland
Tees & North East Yorkshire NHS Trust
West Lane Hospital
Education & Practice Development
Acklam Road
MIDDLESBROUGH TS5 4EE

26/01/2001

Dear Norman McClelland

Cycles of Abuse, the Intergenerational Transmission of Abuse

The Local Research Ethics Committee of Iechyd Morgannwg Health, approved the above study. I would be grateful if you would provide the information required on the enclosed form.

Your response will give vital information about ongoing research in the County as well as feedback on this Committee's activities.

Your reply by Monday **12th February 2001**, (using the enclosed envelope), **by return of post would be very much appreciated.**

Yours sincerely,

MRS NICOLA JOHN
CONSULTANT IN PHARMACEUTICAL PUBLIC HEALTH
DIRECTORATE OF PARTNERSHIP & DEVELOPMENT
& SECRETARY - LOCAL RESEARCH ETHICS COMMITTEE
Enc.

done 8/2/2001

APPENDIX NINE

PhD Anonymised abuse history

CASE 3

Sexually abused aged 9 years, twin sister also sexually abused. Mother gave up care of case 3 when case 3 was 15 years of age. Case 3 reports being scared of Mother because she was so aggressive towards case 3. Case 3 has consistently reported episodes of sexual abuse as a child. Local authority records indicate evidence of emotional and physical abuse of case 3. Case 3 reports sexual abuse as a child by a neighbour, and by an older man when aged 8 or 9. "He kissed me and interfered with me down below, he did the same thing to my sister and a friend of mine who was aged 6".

CASE 5

Case 5 was hit at home by Aunt who lived at case 5's home, this happened until age 17 when case 5 retaliated. Case 5 stated that real Mother lived at the end of the road but grandparents (whom case 5 lived with) would not let case 5 visit her. Case 5's parents separated when case 5 was aged 3. Case 5's grandparents told horrible stories about the Mother. Case 5's grandparent and Aunt seem to have been fairly physically abusive toward case 5.

CASE 7

Describes childhood as violent. Parents often physically fought with each other, Father would hit case 7. Case 7 self reports that when age 14 he was 'kicked out' of school for disruptive behaviour. It is reported that case 7 sniffed glue up to age 16. Case 7 reports that Father was physically abusive and was a heavy drinker, case 7 recalls being punched and spat at and being told that, 'you are a waste of time'. Case 7's over-riding memory of childhood is of parental arguments.

CASE 11

Life characterised by insecurity and instability. Case 11's Father drank heavily, was a stern disciplinarian and was often physically violent toward case 11 and siblings. Case 11's Father was convicted of incest with a female sibling of case 11, and this had a disruptive effect on case 11's life. Case 11's Mother drank alcohol to excess at this time and case 11 developed a stammer and nocturnal enuresis, case 11 also truanted from school and became involved in offending. Case 11 followed siblings into voluntary care when aged 10, (beyond parental control). Case 11 was assessed by a Young Persons Secure Unit because of fire setting behaviour as a child. Case 11 reports that Mother was always swearing and she had been violent from the time case 11 was small. Case 11 remembers being hit 6 times or more with a belt when aged 4 or 5. Case 11 also reports being left in urine soaked sheets for many days, and how the Mother drank during the day. Both parents used to burn case 11's' fingers to prevent case 11 from playing with matches. Case 11 recalls seeing Father punch Mother. Case 11 reports liking school because it took case 11 away from home where case 11 was often locked in a room with siblings and not allowed to talk or read.

CASE 18

Delinquent behaviour since the age of 12. Case 18 has described Father as a drunkard. Case 18 has a history of urinary tract infection from childhood. Case 18 mentioned being seen by a doctor as a child after 2 incidents of sexual abuse from a male friend of the family who lived nearby. Case 18 also stated that Mother discovered a female babysitter masturbating herself and case18 when 18 was 4 about years of age.

CASE 23

As far as case 23 recalls case 23's parents argued considerably, case 23's Father was aggressive though never violent. Case 23 reported no sexual abuse save for one incident when 14 years of age. In a cinema a man fondled case 23 through case 23's clothing. Case 23 allowed this to continue for ten minutes and then walked away.

CASE 26

At age 7 case 26 was subjected to sexual abuse by a man who later received a prison sentence. Case 26 has reported flash backs stating, 'I still see the mans face'. At aged 13 case 26 was abusing solvents and cannabis.

CASE 29

At age 11 case 29 was bullied at school and subjected to homosexual abuse. As a weekly boarder at the school all the boys asked case 29 to masturbate them or provide oral sex. Case 29 stated 'I used to dread going back after weekends'.

CASE 33

Case 33's sister was abused by the Father of the family, a catholic priest who left the priesthood. There are allegations that case 33's Father used to sexually abuse the sister whilst case 33 was in the same room. There are also reports that case 33's Father was close to case 33 in a way which was beyond normal. Case 33's sister, whilst resident in a secure unit alleges that her Father and case 33 (when a child) abused her sexually. Case 33 denies such abuse, experienced or given.

Case 35

At 15 years of age Case 35 reported to a teacher that sexual abuse had occurred within the family and later stated that over the previous 3 years the brother of case 35 had been having full intercourse with case 35. Case 35 also reported physical assaults from the Father of the house and had requested a place of safety. At this time case 35 was admitted briefly to a children's home. Case 35's name had been placed on the 'at risk' register when case 35 was a child. Case 35 was taken to Pakistan and on return reported prolonged sexual abuse by the brother of the household. In 1989 following an admission, case 35 was described as showing temper outbursts, destroying property in a bedroom and scratching wrists, case 35 reported that this was due to the lack of help received in dealing

with past trauma. A referral to the Henderson Hospital was made and case 35 referring doctor's overall view was that case 35 had emotional and behavioural disturbances consistent with past sexual abuse, considering case 35 to be a serious suicide risk. Reports from 1995 indicate that case 35 described flash backs of abuse saying that voices were instructing case 35 to stab a child at the time. An entry within the case reports indicates that case 35 was subject to prolonged and serious sexual abuse during adolescence. Case 35 self-reports whilst in Ashworth Hospital that case 35 had encouraged the brother in sexual abuse at the age of 12. Case 35 acknowledged that being a child these actions from the abuser would be "under control". Case 35 has alleged mental cruelty, constant taunting and ridiculing from the older brother also. Case 35's parent's reaction was one of disbelief. Case 35's Father's reaction and response was to physically and mentally abuse case 35. Notes from Ashworth Hospital indicate that this abuse from the Father took place over a considerable period of time and involved repeated acts of rape. Case 35 has also alleged a rape by the Father when case 35 was aged 10.

Case 40

Case 40 describes the Father of the household as a heavy drinker who was cruel to case 40, the Mother and pets. The Father would be violent to his wife and children and had killed case 40's pet dog. Similarly the Father is reported to have thrown cats onto the road to be run over or had drowned them. On one occasion the Father threw boiling water over case 40 requiring case 40 to attend Casualty. Case 40 left home at age 16 due to problems with the Father.

Case 47

Case 47 is reported to have developed a large bump on the side of the head at age 3 days, remaining until case 47 was 18 months old. Many development milestones occurred in a delayed manner case 41 experiencing problems with speech, requiring involvement with the Speech Therapist from the age of 3 and being seen by an Educational Psychologist during the speech therapy sessions. It was felt that whilst at school case 47 was below average ability. Case 47 has alleged physical and sexual abuse from the age of 15 years by the mathematics teacher at case 47's school. These allegations have been inquired into it is reported that they seem to be unfounded. Case 47 stated that the Maths teacher had hit case 47 at times saying that case 47 deserved to be hit. Regular reports of bruising at this age come from case 47 who also states that the mathematics teacher had inappropriately touched case 47. Case 47's background is characterised by parental divorce, physical abuse and possible sexual abuse, alcohol and substance abuse, poor relations with family members also. In case 47's history there is a history of disturbed family dynamics, many allegations of physical and possible sexual abuse by an elder brother. Case 47 has disclosed that physical abuse from one of the elder brothers occurred.

Case 51

Both case 51's parents are reported to have significant histories of mental illness and to both be significantly aggressive, and both drinking heavily. The Mother left the family home when case 51 was aged 10 years. Case 51's early life was overshadowed by the

acrimonious relationship between the parents, which deteriorated to domestic violence and is reported on one occasion to have resulted in the Father's leg being broken by the Mother using a sewing machine. It is also reported that case 51 was made subject to physical abuse by both parents. Case 51's Father was charged with sexual abuse against case 51, but was found not guilty when the matter came to trial. At age 12 case 51 spent three and a half months in the care of the local authority, during this time case 51 exhibited a range of disturbed behaviours including glue sniffing, self mutilation, and absconding behaviour. Case 51 has alleged sexual abuse by the Father of the house during teenage years. Case 51 also reports many relationships from the age of 14years. The first occasion was with a much older woman whilst case 51 was in residential care. It is alleged that at the time case 51 had a further relationship with another female member of staff at this time. Case 51 has reported a history of great unhappiness describing the Mother of the house as a very violent person who carried out regular physical punishments. On one occasion case 51 reports that the Mother knocked case 51 out by hitting case 51 on the head with a poker. In 1984 case 51's Father was charged with incest with case 51 but the case was dismissed. It is reported that case 51 witnessed many violent outbursts within the family context and experienced violent assaults by both parents, which was the norm. for case 51 throughout the childhood. Case 51 has reported a same sex relationship at the age of 14. Many inappropriate relationships involving carers were reported at this time.

Case 54

During early teenage years case 54 was apparently sexually abused by older boys. This is an experience case 54 has been reluctant to talk about in the past. Case notes indicate that an incident occurred between case 54 and sister involving some sort of inappropriate sexual contact, the details of which are not clear. Case 54 appears to have been affected by this childhood experience and describes feeling in some confusion regarding sexuality. The sexual abuse by older boys is reported in the notes as happening when case 54 was at comprehensive school. Case 54 was sexually abused by all the boys and this created complicated emotions in case 54 who was later unable to discuss what occurred and what seems to have abuse on a relatively regular basis. Case 54 self reports that he found that this experience was both humiliating and quite bad. These older boys were also physically abusive towards case 54 because case 54 was younger than the abusers.

Case 58

According to case 58's Mother the Father of the house was a violent and cruel man who frequently physically assaulted case 58. On one occasion the Father attempted to strangle case 58. The Father was a heavy drinker involved in drug taking and gambling. The parents divorced following the Mothers petition for divorce on the grounds of violence and cruelty. Case 58 is the youngest of 5 children and spent some of childhood in care. All of case 58's siblings have at some time been under the care of Social Services Depts. Because of unsatisfactory home circumstances. Frequent moves as a child led to case 58 being reported as underweight apathetic and responding to human contact by crying when in a Residential Nursery. The parents were subsequently reported by their landlady to the RSPCC for alleged cruelty to one of the sisters of the house. At 1 year of age case 58 was found by a social worker in a cot sodden, with no covers and playing with her own excrement. Case 58 displayed a lack of response to affection and slow development. At

18 months case 58 was abandoned in a local DHSS office. When taken home by the Police, no food was found in the home of case 58. Shortly before the 2nd birthday case 58 was abandoned with the other 2 children in the house with an aunt, and were later received into care. All siblings were taken into care properly prior to case 58's 5th birthday and returned just near to case 58's 5th birthday, home on trial. Six months later all children were taken back into care after marks and bruising had been found on one of the children. The Father was subsequently charged with GBH receiving a 2 year conditional discharge. The 2 other siblings were allowed home on trial again but were taken into care 4 months later. Case 58 remained in care during the next 2 years. Case 58's Mother took up with another man and case 58 was returned home to the Mother on trial leave in 1978, when the Mother subsequently separated from the new boyfriend, the children were once again returned to care. Case 58 later alleged that sexual abuse occurred between the boyfriend of the Mother at this time and case 58. Between 1970 and 1985 case 58 had 14 different placements, living at home with the Mother on 3 separate occasions covering a period of 33 months. Case 58 claims to have had a relationship at age 10 years and experienced sexual intercourse at 12 years with consent. Case notes report that as a baby case 58 experienced gross physical neglect and desertion by the parents. The reports also indicate that it is possible case 58 suffered sexual abuse during childhood, during the period that case 58 lived with the Mother and the cohabitee

Case 64

As a child case 64 reported difficult relationship with of the household Father and how case 64 was unable to confide in him. Case 64 reveals that first sexual contact was with two 17 year old female babysitters when case 64 was aged 13. These 17 year old female babysitters climbed into bed with case 64 and had sexual intercourse with case 64. At the time case 64 claims uncertainty as to what was occurring stating that the 2 young women were in control. Case 64 does not consider this to be an abusive experience. At age 14 case 64 became involved with a girl of a similar age and case 64 has reported a full sexual relationship for 2 years.

Case 72

Case 72's Father was teetotal, did not smoke, and insisted on the same for his children. The Father was reported as hitting the children if they did not go to church, the Father further did not allow the children to read comics or watch television. Case 72 has self-reported in one psychiatric report a description of an unhappy childhood, always being beaten by Father.

Case 86

Case 86 has stated on several occasions that as a child case 86 was a victim of sexual abuse. This abuse occurred when case 86 was 3 or 4 years. However, case 86 has also implied that abuse may have occurred whilst a teenager. Case 86 has cited more than one person to be the perpetrator although on several occasions implied that a babysitter abused case 86. Case 86 has also stated that a stepfather abused case 86 when case 86 was 17.

Case 92

When case 92 was aged 3 years the local authority was sufficiently concerned about the lack of stimulation in the home environment and further suspected physical and sexual abuse of case 92. Records indicate that case 92 suffered from epileptic seizures at this age. School record show that case 92 was withdrawn and benefiting from one to one counselling at a very young age. At age 14 the records indicate that case 92's parents had a turbulent relationship involving violence. Case 92 became a victim of bullying and ill treatment from other children. At age 15 case 92 made allegations of sexual abuse perpetrated by the Father of the household. The local authority obtained an interim care order and case 92 was placed in a residential project. From an early age case 92 was physically beaten by both Mother and Father. Case 92 painfully remembers times when the Mother of the household would hold case 92 down for the Father to beat. Case 92 also disclosed that sexual abuse occurred from age 5, the extent of this abuse being unclear.

Case 96

At a young age case 96's Mother went to America to try and secure work, and returned 2 years later to discover that her husband who had been left in charge of the children was failing to care for them properly, e.g. providing little food, not washing or cleaning for them, and staying out for days at a time.

Case 99

Case 99's teachers expressed concern that case 99 was being bullied at school and that children did not want to play with case 99. Breakdowns between case 99 and the Mother of the household resulted in a case conference with case 99's name being placed on the child protection register. At age 15 years case 99 became pregnant and gave birth to twins. Substance abuse can be traced back to the age of 11 when case 99 was excluded from school for being drunk, using cannabis at the age of 13 also.

Case 102

Case 102 describes childhood as unhappy and unsettled. Case 102 attended boarding school until the age of 11 attending this boarding school because of behavioural disturbances. A child guidance clinic had referred case 102 to this clinic. Allegedly case 102 was repeatedly sexually assaulted at this boarding school between the ages of 12 and 13 by a male resident. This disclosure occurred in 1986 when case 102 was 24 years. At the time case 102 repeatedly requested to leave the school and was later transferred to a local comprehensive school.

Case 108

Case 108 recalls that the parents of the house argued an awful lot when case 108 was growing up, and remembers a time when at age 7 years the Mother tried to stab the Father

with a knife. Case 108 recalls many unhappy memories as a child and many arguments between the parents, and being bullied at school.

Case 114

Case 114 account of family life suggests that considerable tension and conflict within the household. The presence of some domestic violence when case 114 was a young child is in evidence within the notes.

APPENDIX TEN

Table 16: Descriptive Data – Legal Status

legal status

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	3	15	12.8	12.8	12.8
	5(2)	1	.9	.9	13.7
	37	11	9.4	9.4	23.1
	37/41	70	59.8	59.8	82.9
	47/49	10	8.5	8.5	91.5
	48/49	6	5.1	5.1	96.6
	INFORMAL	1	.9	.9	97.4
	48	1	.9	.9	98.3
	38	2	1.7	1.7	100.0
	Total	117	100.0	100.0	

Graph 2: Legal Status

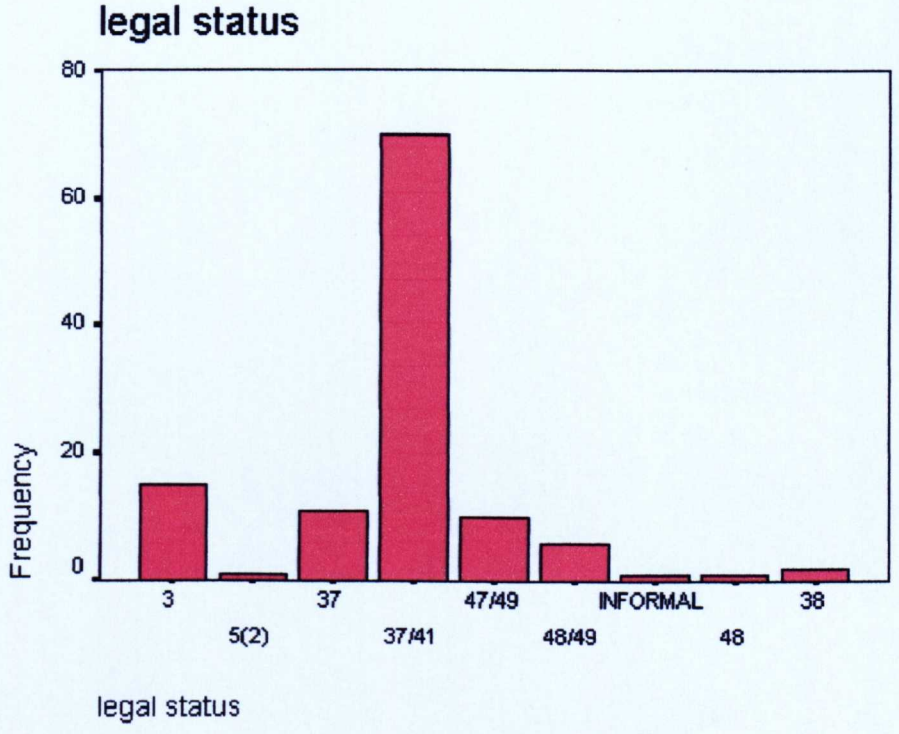


Table 17: Descriptive Data – Marital Status

marital status

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	SINGLE	91	77.8	77.8	77.8
	MARRIED	12	10.3	10.3	88.0
	DIVORCED	7	6.0	6.0	94.0
	UNKNOWN	5	4.3	4.3	98.3
	WIDOWED	2	1.7	1.7	100.0
	Total	117	100.0	100.0	

Graph 3: Marital Status

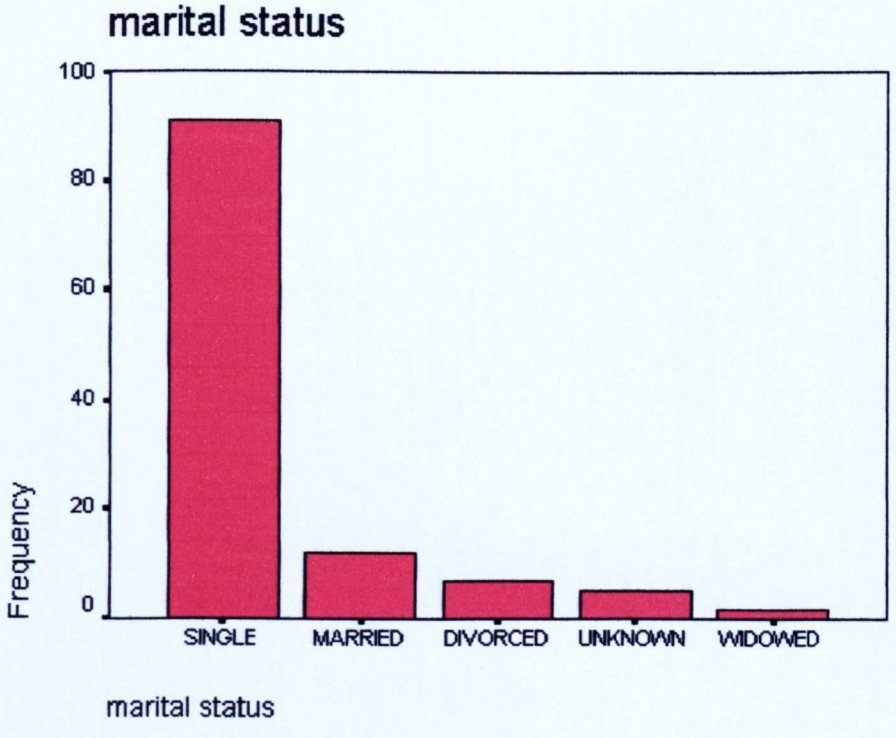
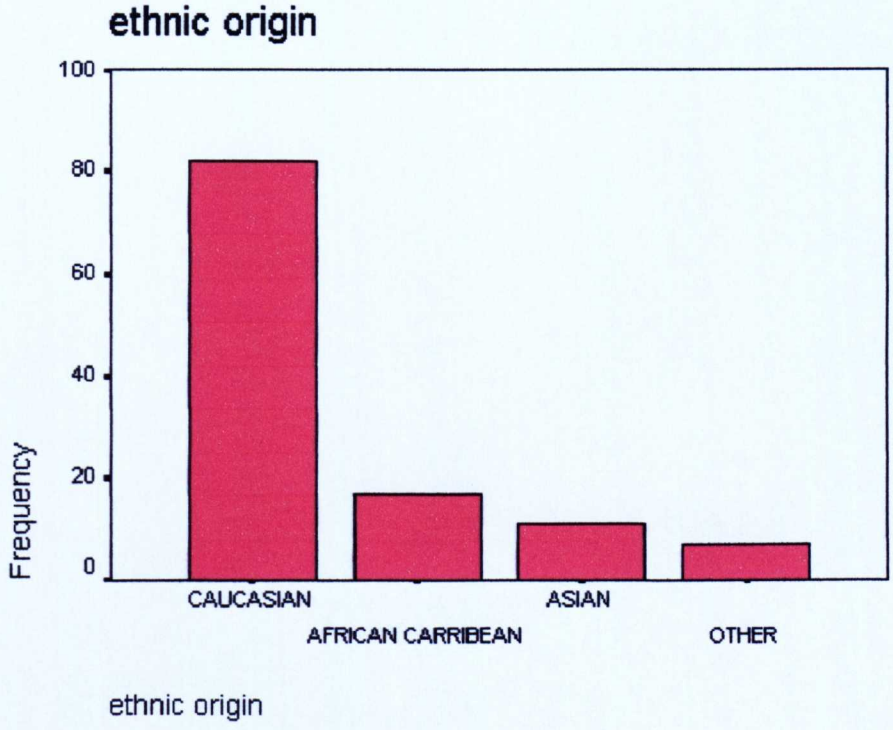


Table 18: Descriptive Data – Ethnic Origin

ethnic origin

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	CAUCASIAN	82	70.1	70.1	70.1
	AFRICAN CARRIBEAN	17	14.5	14.5	84.6
	ASIAN	11	9.4	9.4	94.0
	OTHER	7	6.0	6.0	100.0
	Total	117	100.0	100.0	

Graph 4: Ethnic origin



APPENDIX ELEVEN

Tables 19: Tabulation: Gender/Index Offence

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
gender * index offence	117	100.0%	0	.0%	117	100.0%

gender * index offence Crosstabulation

			index offence		
			VIOLENT	NON VIOLENT	Total
gender	MALE	Count	87	4	91
		Expected Count	85.6	5.4	91.0
	FEMALE	Count	23	3	26
		Expected Count	24.4	1.6	26.0
Total		Count	110	7	117
		Expected Count	110.0	7.0	117.0

Tables 20: Chi-Square Gender Abuse/Neglect Suffered

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
gender * abuse/neglect suffered	117	100.0%	0	.0%	117	100.0%

gender * abuse/neglect suffered Crosstabulation

			abuse/neglect suffered		
			YES	NO	Total
gender	MALE	Count	29	62	91
		Expected Count	37.3	53.7	91.0
	FEMALE	Count	19	7	26
		Expected Count	10.7	15.3	26.0
Total		Count	48	69	117
		Expected Count	48.0	69.0	117.0

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	14.194[b]	1	.000		
Continuity Correction[a]	12.541	1	.000		
Likelihood Ratio	14.209	1	.000		
Fisher's Exact Test				.000	.000
Linear-by-Linear Association	14.072	1	.000		
N of Valid Cases	117				

a. Computed only for a 2x2 table

b. 0 cells (.0%) have expected count less than 5. The minimum expected count is 10.67.

Tables 21: Tabulation: Legal Status Abuse/Neglect Suffered

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
legal status * abuse/neglect suffered	117	100.0%	0	.0%	117	100.0%

legal status * abuse/neglect suffered Crosstabulation

			abuse/neglect suffered		
			YES	NO	Total
legal status	3	Count	5	10	15
		Expected Count	6.2	8.8	15.0
	5(2)	Count	0	1	1
		Expected Count	.4	.6	1.0
	37	Count	8	3	11
		Expected Count	4.5	6.5	11.0
	37/41	Count	27	43	70
		Expected Count	28.7	41.3	70.0
	47/49	Count	5	5	10
		Expected Count	4.1	5.9	10.0
	48/49	Count	2	4	6
		Expected Count	2.5	3.5	6.0
	INFORMAL	Count	0	1	1
		Expected Count	.4	.6	1.0
	48	Count	0	1	1
		Expected Count	.4	.6	1.0
	38	Count	1	1	2
		Expected Count	.8	1.2	2.0
Total		Count	48	69	117
		Expected Count	48.0	69.0	117.0

Tables 22: Tabulation: Index Offence Abuse/Neglect Suffered

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
index offence * abuse/neglect suffered	117	100.0%	0	.0%	117	100.0%

index offence * abuse/neglect suffered Crosstabulation

			abuse/neglect suffered		
			YES	NO	Total
index offence	VIOLENT	Count	47	63	110
		Expected Count	45.1	64.9	110.0
	NON VIOLENT	Count	1	6	7
		Expected Count	2.9	4.1	7.0
Total		Count	48	69	117
		Expected Count	48.0	69.0	117.0

APPENDIX TWELVE

Tables 23: Mean Age Calculation (n=117)

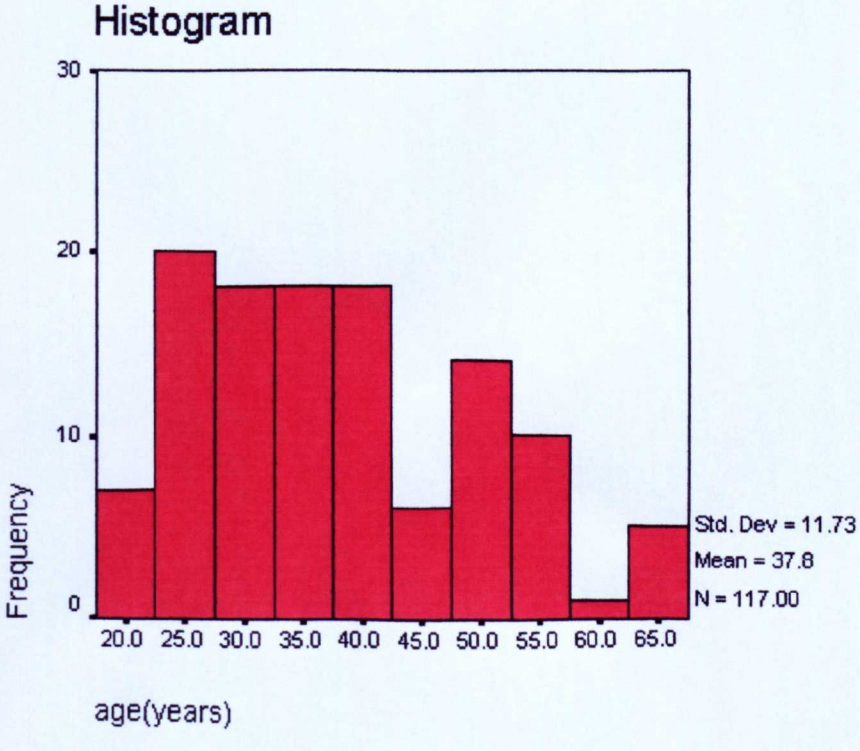
Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
age(years)	117	100.0%	0	.0%	117	100.0%

Descriptives

			Statistic	Std. Error
age(years)	Mean		37.83	1.08
	95% Confidence Interval for Mean	Lower Bound	35.68	
		Upper Bound	39.98	
	5% Trimmed Mean		37.37	
	Median		36.00	
	Variance		137.643	
	Std. Deviation		11.73	
	Minimum		20	
	Maximum		65	
	Range		45	
	Interquartile Range		19.50	
	Skewness		.502	.224
	Kurtosis		-.646	.444

Graph 5: Mean Age Histogram (n=117)



APPENDIX THIRTEEN

Tables 24: Tabulation: Marital Status Abuse/Neglect Suffered

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
marital status * abuse/neglect suffered	117	100.0%	0	.0%	117	100.0%

marital status * abuse/neglect suffered Crosstabulation

			abuse/neglect suffered		
			YES	NO	Total
marital status	SINGLE	Count	42	49	91
		Expected Count	39.7	51.3	91.0
	MARRIED	Count	3	9	12
		Expected Count	5.2	6.8	12.0
	DIVORCED	Count	3	4	7
		Expected Count	3.1	3.9	7.0
Total		Count	48	62	110
		Expected Count	48.0	62.0	110.0

Tables 25: Tabulation: Ethnicity Abuse/Neglect Suffered

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
ethnic origin * abuse/neglect suffered	110	94.0%	7	6.0%	117	100.0%

ethnic origin * abuse/neglect suffered Crosstabulation

			abuse/neglect suffered		
			YES	NO	Total
ethnic origin	CAUCASIAN	Count	37	45	82
		Expected Count	35.0	47.0	82.0
	AFRICAN CARRIBEAN	Count	6	11	17
		Expected Count	7.3	9.7	17.0
	ASIAN	Count	4	7	11
		Expected Count	4.7	6.3	11.0
Total		Count	47	63	110
		Expected Count	47.0	63.0	110.0

Tables 26: Tabulation: Gender Marital Status

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
gender * marital status	110	94.0%	7	6.0%	117	100.0%

gender * marital status Crosstabulation

			marital status			
			SINGLE	MARRIED	DIVORCED	Total
gender	MALE	Count	69	11	4	84
		Expected Count	69.5	9.2	5.3	84.0
	FEMALE	Count	22	1	3	26
		Expected Count	21.5	2.8	1.7	26.0
Total		Count	91	12	7	110
		Expected Count	91.0	12.0	7.0	110.0

APPENDIX FOURTEEN

Tables 27: Kappa Values: Benchmark Nurse v Nurse Respondents

```
FLIP performed on 34 cases and 24 variables, creating 24 cases
and 35 variables.  The working file has been replaced.

A new variable has been created called CASE_LBL.  Its
contents are the old variable names.

New variable names:

CASE_LBL VAR001   VAR002   VAR003   VAR004   VAR005   VAR006
VAR007   VAR008   VAR009   VAR010   VAR011   VAR012   VAR013
VAR014   VAR015   VAR016   VAR017   VAR018   VAR019   VAR020
VAR021   VAR022   VAR023   VAR024   VAR025   VAR026   VAR027
VAR028   VAR029   VAR030   VAR031   VAR032   VAR033   VAR034
```

Case Processing Summary

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
VAR001 * VAR034	22	91.7%	2	8.3%	24	100.0%

VAR001 * VAR034 Crosstabulation

Count

		VAR034				Total
		1.00	2.00	3.00	4.00	
VAR001	1.00	3				3
	2.00	2	1	3		6
	3.00		4	7	1	12
	4.00				1	1
Total		5	5	10	2	22

Symmetric Measures

		Value	Asymp. Std. Error[a]	Approx. T[b]	Approx. Sig.
Measure of Agreement	Kappa	.306	.164	2.258	.024
N of Valid Cases		22			

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

Crosstabs

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
VAR001 * VAR034	22	91.7%	2	8.3%	24	100.0%
VAR002 * VAR034	21	87.5%	3	12.5%	24	100.0%
VAR003 * VAR034	24	100.0%	0	.0%	24	100.0%
VAR004 * VAR034	24	100.0%	0	.0%	24	100.0%
VAR005 * VAR034	24	100.0%	0	.0%	24	100.0%
VAR006 * VAR034	24	100.0%	0	.0%	24	100.0%
VAR007 * VAR034	24	100.0%	0	.0%	24	100.0%
VAR008 * VAR034	24	100.0%	0	.0%	24	100.0%
VAR009 * VAR034	24	100.0%	0	.0%	24	100.0%
VAR010 * VAR034	24	100.0%	0	.0%	24	100.0%
VAR011 * VAR034	24	100.0%	0	.0%	24	100.0%
VAR012 * VAR034	24	100.0%	0	.0%	24	100.0%
VAR013 * VAR034	23	95.8%	1	4.2%	24	100.0%
VAR014 * VAR034	24	100.0%	0	.0%	24	100.0%
VAR015 * VAR034	24	100.0%	0	.0%	24	100.0%
VAR016 * VAR034	24	100.0%	0	.0%	24	100.0%
VAR017 * VAR034	24	100.0%	0	.0%	24	100.0%
VAR018 * VAR034	24	100.0%	0	.0%	24	100.0%
VAR019 * VAR034	24	100.0%	0	.0%	24	100.0%
VAR020 * VAR034	24	100.0%	0	.0%	24	100.0%
VAR021 * VAR034	24	100.0%	0	.0%	24	100.0%
VAR022 * VAR034	24	100.0%	0	.0%	24	100.0%
VAR023 * VAR034	24	100.0%	0	.0%	24	100.0%
VAR024 * VAR034	24	100.0%	0	.0%	24	100.0%
VAR025 * VAR034	24	100.0%	0	.0%	24	100.0%
VAR026 * VAR034	24	100.0%	0	.0%	24	100.0%
VAR027 * VAR034	24	100.0%	0	.0%	24	100.0%
VAR028 * VAR034	23	95.8%	1	4.2%	24	100.0%
VAR029 * VAR034	24	100.0%	0	.0%	24	100.0%
VAR030 * VAR034	24	100.0%	0	.0%	24	100.0%
VAR031 * VAR034	19	79.2%	5	20.8%	24	100.0%
VAR032 * VAR034	24	100.0%	0	.0%	24	100.0%
VAR033 * VAR034	24	100.0%	0	.0%	24	100.0%

VAR001 * VAR034

Crosstab

Count

		VAR034				
		1.00	2.00	3.00	4.00	Total
VAR001	1.00	3				3
	2.00	2	1	3		6
	3.00		4	7	1	12
	4.00				1	1
Total		5	5	10	2	22

Symmetric Measures

		Value	Asymp. Std. Error[a]	Approx. T[b]	Approx. Sig.
Measure of Agreement	Kappa	.306	.164	2.258	.024
N of Valid Cases		22			

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

VAR002 * VAR034

Crosstab

Count

		VAR034				
		1.00	2.00	3.00	4.00	Total
VAR002	1.00	4		2		6
	2.00	1	3	3		7
	3.00		1	4		5
	4.00			1	2	3
Total		5	4	10	2	21

Symmetric Measures

		Value	Asymp. Std. Error[a]	Approx. T[b]	Approx. Sig.
Measure of Agreement	Kappa	.486	.141	3.981	.000
N of Valid Cases		21			

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

VAR003 * VAR034

Crosstab

Count

		VAR034				
		1.00	2.00	3.00	4.00	Total
VAR003	1.00	3	4	3		10
	2.00	1	2	8		11
	3.00	1			2	3
Total		5	6	11	2	24

Symmetric Measures

		Value
Measure of Agreement	Kappa	.[a]
N of Valid Cases		24

a. Kappa statistics cannot be computed.They require a symmetric 2-way table in which the values of the first variable match the values of the second variable.

VAR004 * VAR034

Crosstab

Count

		VAR034				
		1.00	2.00	3.00	4.00	Total
VAR004	1.00	3	1			4
	2.00	2	4	6		12
	3.00		1	5	1	7
	4.00				1	1
Total		5	6	11	2	24

Symmetric Measures

		Value	Asymp. Std. Error[a]	Approx. T[b]	Approx. Sig.
Measure of Agreement	Kappa	.348	.144	2.846	.004
N of Valid Cases		24			

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

VAR005 * VAR034

Crosstab

Count

		VAR034				
		1.00	2.00	3.00	4.00	Total
VAR005	1.00	3	3	2		8
	2.00	2	2	7		11
	3.00		1	2	1	4
	4.00				1	1
Total		5	6	11	2	24

Symmetric Measures

		Value	Asymp. Std. Error[a]	Approx. T[b]	Approx. Sig.
Measure of Agreement	Kappa	.094	.132	.834	.405
N of Valid Cases		24			

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

VAR006 * VAR034

Crosstab

Count

		VAR034				
		1.00	2.00	3.00	4.00	Total
VAR006	1.00	5	3	2		10
	2.00		2	5		7
	3.00		1	4	2	7
Total		5	6	11	2	24

Symmetric Measures

		Value
Measure of Agreement	Kappa	.[a]
N of Valid Cases		24

a. Kappa statistics cannot be computed.They require a symmetric 2-way table in which the values of the first variable match the values of the second variable.

VAR007 * VAR034

Crosstab

Count

		VAR034				
		1.00	2.00	3.00	4.00	Total
VAR007	1.00	2		1		3
	2.00	2	3	1		6
	3.00		2	6	1	9
	4.00	1	1	3	1	6
Total		5	6	11	2	24

Symmetric Measures

		Value	Asymp. Std. Error[a]	Approx. T[b]	Approx. Sig.
Measure of Agreement	Kappa	.304	.135	2.597	.009
N of Valid Cases		24			

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

VAR008 * VAR034

Crosstab

Count

		VAR034				
		1.00	2.00	3.00	4.00	Total
VAR008	1.00	3	1			4
	2.00	2	1	5		8
	3.00		4	6		10
	4.00				2	2
Total		5	6	11	2	24

Symmetric Measures

		Value	Asymp. Std. Error[a]	Approx. T[b]	Approx. Sig.
Measure of Agreement	Kappa	.269	.162	2.091	.037
N of Valid Cases		24			

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

VAR009 * VAR034

Crosstab

Count

		VAR034				Total
		1.00	2.00	3.00	4.00	
VAR009	1.00	3	2			5
	2.00	1	2	4		7
	3.00	1	2	4	1	8
	4.00			3	1	4
Total		5	6	11	2	24

Symmetric Measures

		Value	Asymp. Std. Error[a]	Approx. T[b]	Approx. Sig.
Measure of Agreement	Kappa	.186	.143	1.539	.124
N of Valid Cases		24			

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

VAR010 * VAR034

Crosstab

Count

		VAR034				Total
		1.00	2.00	3.00	4.00	
VAR010	1.00	3	3	2		8
	2.00	1	2	7		10
	3.00	1	1	2	2	6
Total		5	6	11	2	24

Symmetric Measures

		Value
Measure of Agreement	Kappa	.[a]
N of Valid Cases		24

a. Kappa statistics cannot be computed.They require a symmetric 2-way table in which the values of the first variable match the values of the second variable.

VAR011 * VAR034

Crosstab

Count

		VAR034				Total
		1.00	2.00	3.00	4.00	
VAR011	1.00	4		2		6
	2.00		3	2		5
	3.00	1	3	6	1	11
	4.00			1	1	2
Total		5	6	11	2	24

Symmetric Measures

		Value	Asymp. Std. Error[a]	Approx. T[b]	Approx. Sig.
Measure of Agreement	Kappa	.386	.155	3.003	.003
N of Valid Cases		24			

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

VAR012 * VAR034

Crosstab

Count

		VAR034				Total
		1.00	2.00	3.00	4.00	
VAR012	1.00	4	1			5
	2.00		3	4		7
	3.00	1	2	5	1	9
	4.00			2	1	3
Total		5	6	11	2	24

Symmetric Measures

		Value	Asymp. Std. Error[a]	Approx. T[b]	Approx. Sig.
Measure of Agreement	Kappa	.347	.150	2.770	.006
N of Valid Cases		24			

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

VAR013 * VAR034

Crosstab

Count

		VAR034				Total
		1.00	2.00	3.00	4.00	
VAR013	1.00	1				1
	2.00	3	4	1		8
	3.00	1	1	5		7
	4.00			5	2	7
Total		5	5	11	2	23

Symmetric Measures

		Value	Asymp. Std. Error[a]	Approx. T[b]	Approx. Sig.
Measure of Agreement	Kappa	.356	.127	3.237	.001
N of Valid Cases		23			

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

VAR014 * VAR034

Crosstab

Count

		VAR034				Total
		1.00	2.00	3.00	4.00	
VAR014	1.00	1				1
	2.00		3	1		4
	3.00	4	2	4	1	11
	4.00		1	6	1	8
Total		5	6	11	2	24

Symmetric Measures

		Value	Asymp. Std. Error[a]	Approx. T[b]	Approx. Sig.
Measure of Agreement	Kappa	.122	.139	1.107	.268
N of Valid Cases		24			

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

VAR015 * VAR034

Crosstab

Count

		VAR034				
		1.00	2.00	3.00	4.00	Total
VAR015	1.00	2				2
	2.00	2	1	2		5
	3.00	1	5	9	2	17
Total		5	6	11	2	24

Symmetric Measures

		Value
Measure of Agreement	Kappa	.[a]
N of Valid Cases		24

a. Kappa statistics cannot be computed.They require a symmetric 2-way table in which the values of the first variable match the values of the second variable.

VAR016 * VAR034

Crosstab

Count

		VAR034				
		1.00	2.00	3.00	4.00	Total
VAR016	1.00	1				1
	2.00	3	1	2		6
	3.00	1	5	7	1	14
	4.00			2	1	3
Total		5	6	11	2	24

Symmetric Measures

		Value	Asymp. Std. Error[a]	Approx. T[b]	Approx. Sig.
Measure of Agreement	Kappa	.104	.144	.838	.402
N of Valid Cases		24			

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

VAR017 * VAR034

Crosstab

Count

		VAR034				
		1.00	2.00	3.00	4.00	Total
VAR017	1.00	2	1	1		4
	2.00	2	3	5		10
	3.00	1	2	3		6
	4.00			2	2	4
Total		5	6	11	2	24

Symmetric Measures

		Value	Asymp. Std. Error[a]	Approx. T[b]	Approx. Sig.
Measure of Agreement	Kappa	.204	.142	1.765	.078
N of Valid Cases		24			

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

VAR018 * VAR034

Crosstab

Count

		VAR034				
		1.00	2.00	3.00	4.00	Total
VAR018	1.00	3	1			4
	2.00	1	2	3		6
	3.00	1	3	2	1	7
	4.00			6	1	7
Total		5	6	11	2	24

Symmetric Measures

		Value	Asymp. Std. Error[a]	Approx. T[b]	Approx. Sig.
Measure of Agreement	Kappa	.105	.136	.937	.349
N of Valid Cases		24			

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

VAR019 * VAR034

Crosstab

Count

		VAR034				
		1.00	2.00	3.00	4.00	Total
VAR019	1.00	2	1	1		4
	2.00	2	5	6		13
	3.00	1		4	2	7
Total		5	6	11	2	24

Symmetric Measures

		Value
Measure of Agreement	Kappa	.[a]
N of Valid Cases		24

a. Kappa statistics cannot be computed.They require a symmetric 2-way table in which the values of the first variable match the values of the second variable.

VAR020 * VAR034

Crosstab

Count

		VAR034				
		1.00	2.00	3.00	4.00	Total
VAR020	1.00	1	3	1		5
	2.00	2	1	4		7
	3.00	2	2	5		9
	4.00			1	2	3
Total		5	6	11	2	24

Symmetric Measures

		Value	Asymp. Std. Error[a]	Approx. T[b]	Approx. Sig.
Measure of Agreement	Kappa	.109	.145	.871	.384
N of Valid Cases		24			

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

VAR021 * VAR034

Crosstab

Count

		VAR034				
		1.00	2.00	3.00	4.00	Total
VAR021	1.00	2	2			4
	2.00	2	4	3		9
	3.00	1		7		8
	4.00			1	2	3
Total		5	6	11	2	24

Symmetric Measures

		Value	Asymp. Std. Error[a]	Approx. T[b]	Approx. Sig.
Measure of Agreement	Kappa	.471	.136	3.828	.000
N of Valid Cases		24			

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

VAR022 * VAR034

Crosstab

Count

		VAR034				
		1.00	2.00	3.00	4.00	Total
VAR022	1.00		1	2		3
	2.00	4	4	8		16
	3.00	1	1	1	2	5
Total		5	6	11	2	24

Symmetric Measures

		Value
Measure of Agreement	Kappa	.[a]
N of Valid Cases		24

a. Kappa statistics cannot be computed.They require a symmetric 2-way table in which the values of the first variable match the values of the second variable.

VAR023 * VAR034

Crosstab

Count

		VAR034				
		1.00	2.00	3.00	4.00	Total
VAR023	1.00	1	2	1		4
	2.00	1	1	1		3
	3.00	3	3	5		11
	4.00			4	2	6
Total		5	6	11	2	24

Symmetric Measures

		Value	Asymp. Std. Error[a]	Approx. T[b]	Approx. Sig.
Measure of Agreement	Kappa	.111	.135	.955	.340
N of Valid Cases		24			

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

VAR024 * VAR034

Crosstab

Count

		VAR034				
		1.00	2.00	3.00	4.00	Total
VAR024	1.00	2	2	3		7
	2.00	3	3	4		10
	3.00		1	2	2	5
	4.00			2		2
Total		5	6	11	2	24

Symmetric Measures

		Value	Asymp. Std. Error[a]	Approx. T[b]	Approx. Sig.
Measure of Agreement	Kappa	.033	.116	.285	.775
N of Valid Cases		24			

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

VAR025 * VAR034

Crosstab

Count

		VAR034				
		1.00	2.00	3.00	4.00	Total
VAR025	1.00	1	2	2		5
	2.00	4	3	3		10
	3.00		1	4		5
	4.00			2	2	4
Total		5	6	11	2	24

Symmetric Measures

		Value	Asymp. Std. Error[a]	Approx. T[b]	Approx. Sig.
Measure of Agreement	Kappa	.215	.132	1.907	.056
N of Valid Cases		24			

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

VAR026 * VAR034

Crosstab

Count

		VAR034				
		1.00	2.00	3.00	4.00	Total
VAR026	1.00	1	3	2		6
	2.00	3	2	2		7
	3.00	1	1	6	1	9
	4.00			1	1	2
Total		5	6	11	2	24

Symmetric Measures

		Value	Asymp. Std. Error[a]	Approx. T[b]	Approx. Sig.
Measure of Agreement	Kappa	.162	.137	1.274	.203
N of Valid Cases		24			

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

VAR027 * VAR034

Crosstab

Count

		VAR034				
		1.00	2.00	3.00	4.00	Total
VAR027	1.00	1	3	2		6
	2.00	3	1	6		10
	3.00	1	2	2	1	6
	4.00			1	1	2
Total		5	6	11	2	24

Symmetric Measures

		Value	Asymp. Std. Error[a]	Approx. T[b]	Approx. Sig.
Measure of Agreement	Kappa	-.096	.126	-.803	.422
N of Valid Cases		24			

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

VAR028 * VAR034

Crosstab

Count

		VAR034				
		1.00	2.00	3.00	4.00	Total
VAR028	1.00	2	1	1		4
	2.00	1		2	1	4
	3.00	1	3	3		7
	4.00		2	5	1	8
Total		4	6	11	2	23

Symmetric Measures

		Value	Asymp. Std. Error[a]	Approx. T[b]	Approx. Sig.
Measure of Agreement	Kappa	.013	.118	.114	.909
N of Valid Cases		23			

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

VAR029 * VAR034

Crosstab

Count

		VAR034				
		1.00	2.00	3.00	4.00	Total
VAR029	1.00	3	1	2		6
	2.00	2	5	4		11
	3.00			4	1	5
	4.00			1	1	2
Total		5	6	11	2	24

Symmetric Measures

		Value	Asymp. Std. Error[a]	Approx. T[b]	Approx. Sig.
Measure of Agreement	Kappa	.373	.130	3.223	.001
N of Valid Cases		24			

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

VAR030 * VAR034

Crosstab

Count

		VAR034				
		1.00	2.00	3.00	4.00	Total
VAR030	1.00		2	1		3
	2.00	3	2	3		8
	3.00		2	2		4
	4.00	2		5	2	9
Total		5	6	11	2	24

Symmetric Measures

		Value	Asymp. Std. Error[a]	Approx. T[b]	Approx. Sig.
Measure of Agreement	Kappa	.042	.103	.425	.671
N of Valid Cases		24			

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

VAR031 * VAR034

Crosstab

Count

		VAR034				
		1.00	2.00	3.00	4.00	Total
VAR031	1.00	1	1			2
	2.00	2	2	1		5
	3.00	1	1	7		9
	4.00			1	2	3
Total		4	4	9	2	19

Symmetric Measures

		Value	Asymp. Std. Error[a]	Approx. T[b]	Approx. Sig.
Measure of Agreement	Kappa	.459	.154	3.311	.001
N of Valid Cases		19			

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

VAR032 * VAR034

Crosstab

Count

		VAR034				
		1.00	2.00	3.00	4.00	Total
VAR032	1.00	1	2			3
	2.00	1	1	2		4
	3.00	3	3	9	1	16
	4.00				1	1
Total		5	6	11	2	24

Symmetric Measures

		Value	Asymp. Std. Error[a]	Approx. T[b]	Approx. Sig.
Measure of Agreement	Kappa	.198	.142	1.567	.117
N of Valid Cases		24			

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

VAR033 * VAR034

Crosstab

Count

		VAR034				
		1.00	2.00	3.00	4.00	Total
VAR033	2.00	2	2	4		8
	3.00	3		5		8
	4.00		4	2	2	8
Total		5	6	11	2	24

Symmetric Measures

		Value
Measure of Agreement	Kappa	.[a]
N of Valid Cases		24

a. Kappa statistics cannot be computed.They require a symmetric 2-way table in which the values of the first variable match the values of the second variable.

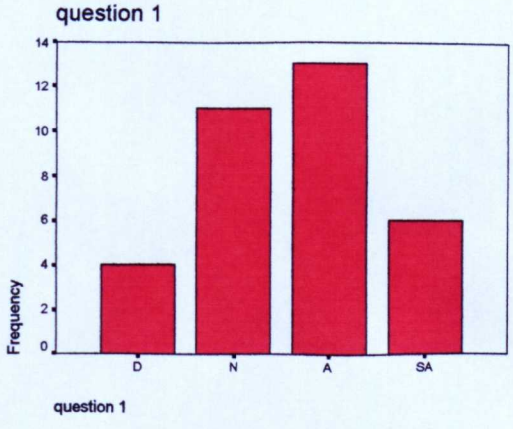
APPENDIX FIFTEEN

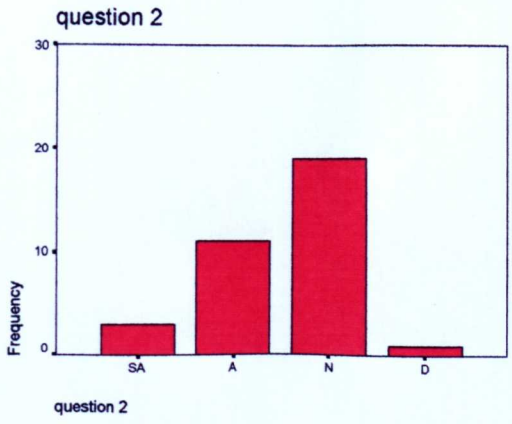
Table 28: Rounded Means: Knowledge and Opinion Questionnaire

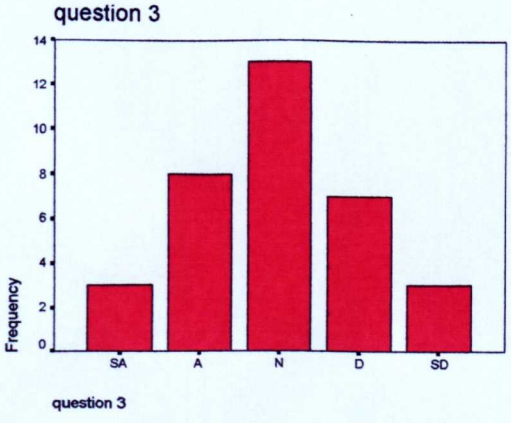
Rounded Means

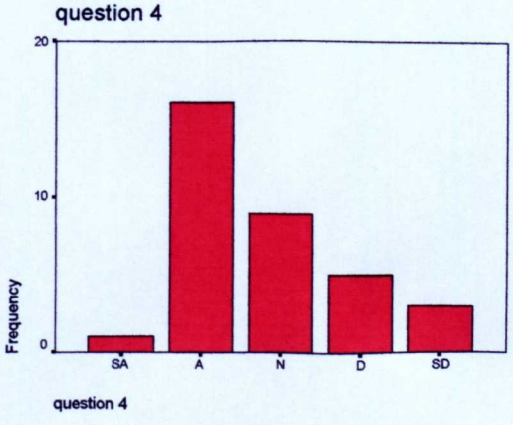
	Mean
question 1	4
question 2	3
question 3	3
question 4	3
question 5	4
question 6	3
question 7	4
question 8	3
question 9	3
question 10	4
question 11	3
question 12	4
question 13	4
question 14	2
question 15	2

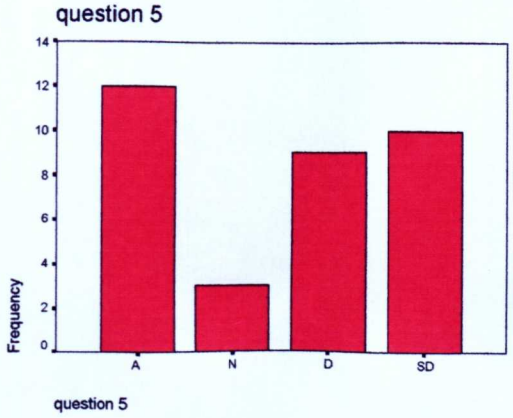
Graphs 6: Graphical Display: Knowledge and Opinion Questionnaire Frequency of Agreement, Non-Agreement

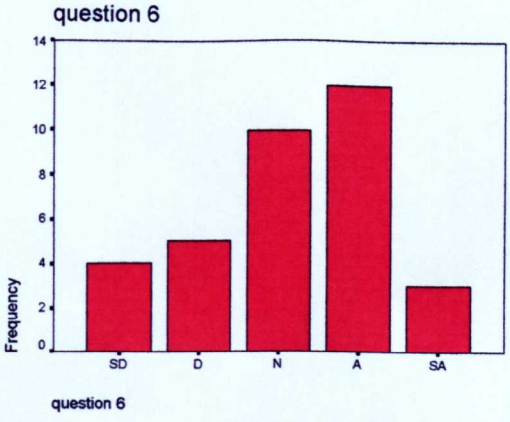


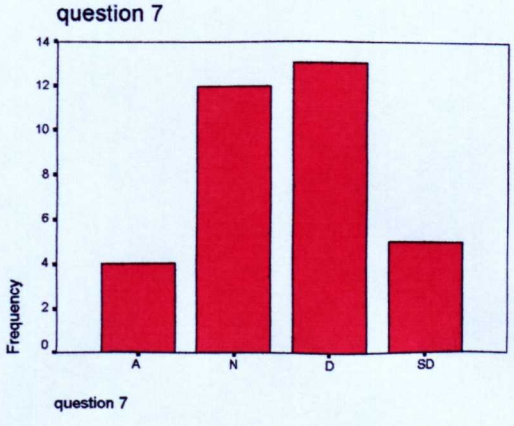

question 2
30
20
10
0
Frequency
SA
A
N
D
question 2

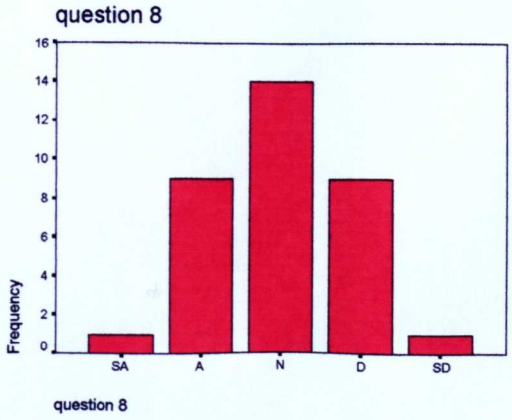

question 3
14
12
10
8
6
4
2
0
Frequency
SA
A
N
D
SD
question 3

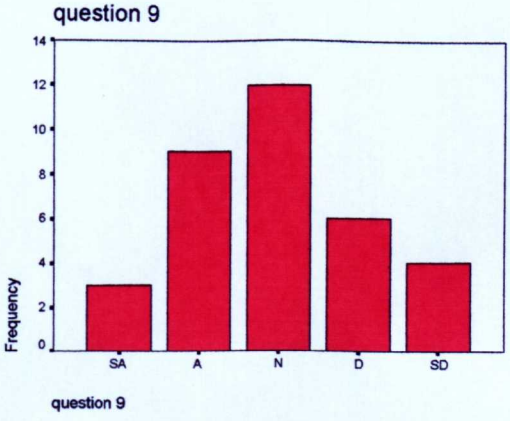

question 4
20
10
0
Frequency
SA
A
N
D
SD
question 4

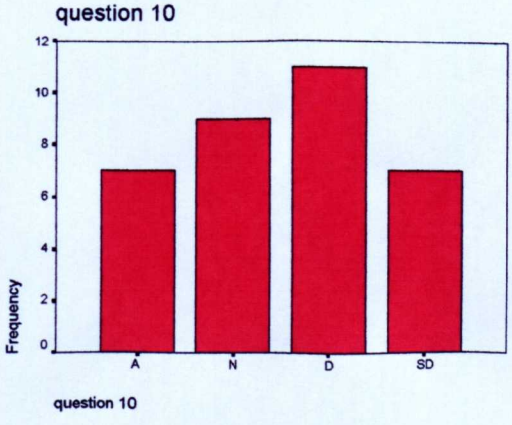

question 5
Frequency
14
12
10
8
6
4
2
0
A
N
D
SD
question 5

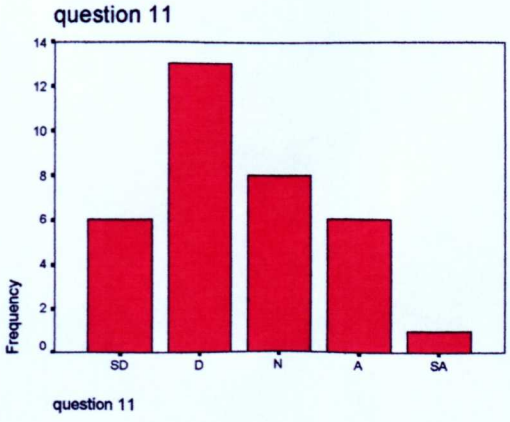

question 6
Frequency
14
12
10
8
6
4
2
0
SD
D
N
A
SA
question 6

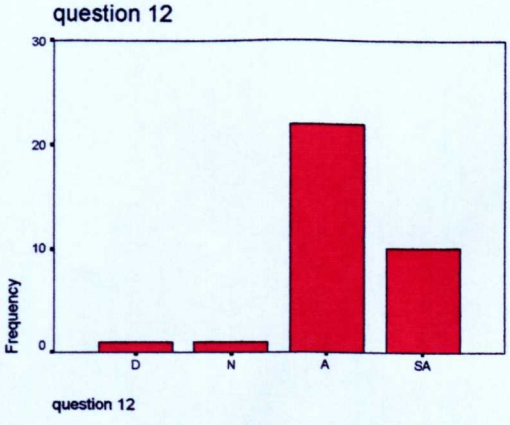

question 7
Frequency
14
12
10
8
6
4
2
0
A
N
D
SD
question 7

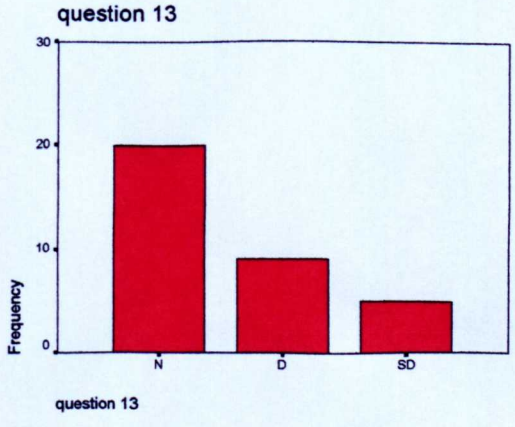

question 8
16
14
12
10
8
6
4
2
0
Frequency
SA
A
N
D
SD
question 8

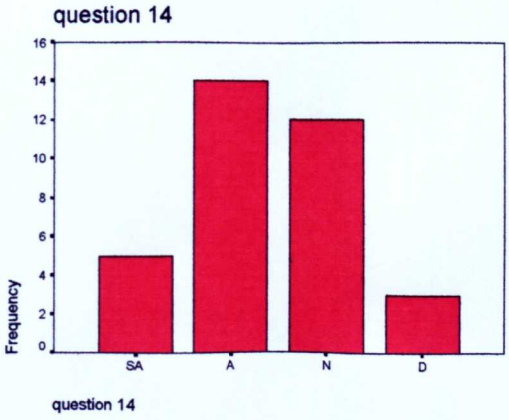

question 9
14
12
10
8
6
4
2
0
Frequency
SA
A
N
D
SD
question 9

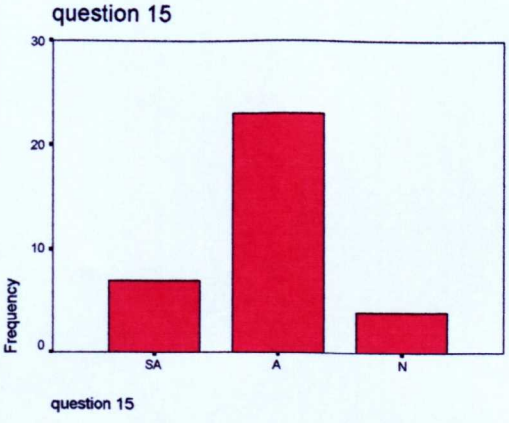

question 10
12
10
8
6
4
2
0
Frequency
A
N
D
SD
question 10


question 11
14
12
10
8
6
4
2
0
Frequency
SD
D
N
A
SA
question 11


question 12
30
20
10
0
Frequency
D
N
A
SA
question 12


question 13
30
20
10
0
Frequency
N
D
SD
question 13


question 14
16
14
12
10
8
6
4
2
0
Frequency
SA
A
N
D
question 14


question 15
30
20
10
0
Frequency
SA
A
N
question 15

APPENDIX SIXTEEN

Analysis of Variance (undertaken on more than two variables. If done on two variables only will give same result as a t-test. You have this for gender and yes/no variables)

H_o – no difference between means
H_1 – at least one of the means is different

Support H_o if significance above 0.05
Support H_1 if significance below 0.05

For ANOVA

1. **No differences observed on any responses for Profession**

The observation supports the null hypotheses as significance value greater than 0.05

Tables 29: ANOVA Profession

Descriptives

		N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
						Lower Bound	Upper Bound		
question 1	PSYCHIATRIST	10	3.60	1.075	.340	2.83	4.37	2	5
	SOCIAL WORKER	3	3.67	1.528	.882	-.13	7.46	2	5
	OCCUPATIONAL THERAPIST	5	4.00	1.000	.447	2.76	5.24	3	5
	PSYCHOLOGIST	2	3.50	.707	.500	-2.85	9.85	3	4
	NURSE	14	3.50	.760	.203	3.06	3.94	2	5
	Total	34	3.62	.922	.158	3.30	3.94	2	5
question 2	PSYCHIATRIST	10	2.60	.699	.221	2.10	3.10	2	4
	SOCIAL WORKER	3	3.00	.000	.000	3.00	3.00	3	3
	OCCUPATIONAL THERAPIST	5	2.00	.707	.316	1.12	2.88	1	3
	PSYCHOLOGIST	2	2.50	.707	.500	-3.85	8.85	2	3
	NURSE	14	2.57	.756	.202	2.13	3.01	1	3
	Total	34	2.53	.706	.121	2.28	2.78	1	4
question 3	PSYCHIATRIST	10	2.90	.876	.277	2.27	3.53	1	4
	SOCIAL WORKER	3	2.67	.577	.333	1.23	4.10	2	3
	OCCUPATIONAL THERAPIST	5	2.40	1.140	.510	.98	3.82	1	4
	PSYCHOLOGIST	2	5.00	.000	.000	5.00	5.00	5	5
	NURSE	14	3.00	1.109	.296	2.36	3.64	1	5
	Total	34	2.97	1.087	.186	2.59	3.35	1	5
question 4	PSYCHIATRIST	10	3.10	1.101	.348	2.31	3.89	2	5
	SOCIAL WORKER	3	2.67	.577	.333	1.23	4.10	2	3
	OCCUPATIONAL THERAPIST	5	3.20	.837	.374	2.16	4.24	2	4
	PSYCHOLOGIST	2	4.00	1.414	1.000	-8.71	16.71	3	5
	NURSE	14	2.29	.914	.244	1.76	2.81	1	5
	Total	34	2.79	1.038	.178	2.43	3.16	1	5
question 5	PSYCHIATRIST	10	3.00	1.333	.422	2.05	3.95	2	5
	SOCIAL WORKER	3	3.33	1.528	.882	-.46	7.13	2	5
	OCCUPATIONAL THERAPIST	5	4.00	1.000	.447	2.76	5.24	3	5
	PSYCHOLOGIST	2	3.50	2.121	1.500	-15.56	22.56	2	5
	NURSE	14	3.71	1.204	.322	3.02	4.41	2	5
	Total	34	3.50	1.261	.216	3.06	3.94	2	5
question 6	PSYCHIATRIST	10	3.40	1.174	.371	2.56	4.24	1	5
	SOCIAL WORKER	3	4.00	1.000	.577	1.52	6.48	3	5
	OCCUPATIONAL THERAPIST	5	2.80	1.304	.583	1.18	4.42	1	4
	PSYCHOLOGIST	2	3.00	.000	.000	3.00	3.00	3	3
	NURSE	14	2.93	1.207	.322	2.23	3.63	1	5
	Total	34	3.15	1.158	.199	2.74	3.55	1	5
question 7	PSYCHIATRIST	10	3.80	1.033	.327	3.06	4.54	2	5
	SOCIAL WORKER	3	4.00	.000	.000	4.00	4.00	4	4
	OCCUPATIONAL THERAPIST	5	4.00	1.000	.447	2.76	5.24	3	5
	PSYCHOLOGIST	2	3.00	.000	.000	3.00	3.00	3	3
	NURSE	14	3.21	.802	.214	2.75	3.68	2	4
	Total	34	3.56	.894	.153	3.25	3.87	2	5
question 8	PSYCHIATRIST	10	2.70	1.160	.367	1.87	3.53	1	5
	SOCIAL WORKER	3	3.00	1.000	.577	.52	5.48	2	4
	OCCUPATIONAL THERAPIST	5	3.60	.548	.245	2.92	4.28	3	4
	PSYCHOLOGIST	2	3.50	.707	.500	-2.85	9.85	3	4
	NURSE	14	2.93	.730	.195	2.51	3.35	2	4
	Total	34	3.00	.888	.152	2.69	3.31	1	5
question 9	PSYCHIATRIST	10	3.20	.789	.249	2.64	3.76	2	4
	SOCIAL WORKER	3	2.67	.577	.333	1.23	4.10	2	3
	OCCUPATIONAL THERAPIST	5	3.20	1.789	.800	.98	5.42	1	5
	PSYCHOLOGIST	2	4.00	1.414	1.000	-8.71	16.71	3	5
	NURSE	14	2.64	1.151	.308	1.98	3.31	1	5
	Total	34	2.97	1.141	.196	2.57	3.37	1	5
question 10	PSYCHIATRIST	10	3.70	1.059	.335	2.94	4.46	2	5
	SOCIAL WORKER	3	3.00	1.000	.577	.52	5.48	2	4
	OCCUPATIONAL THERAPIST	5	4.40	.894	.400	3.29	5.51	3	5
	PSYCHOLOGIST	2	4.00	.000	.000	4.00	4.00	4	4
	NURSE	14	3.14	1.027	.275	2.55	3.74	2	5
	Total	34	3.53	1.051	.180	3.16	3.90	2	5
question 11	PSYCHIATRIST	10	1.80	1.033	.327	1.06	2.54	1	4
	SOCIAL WORKER	3	2.67	.577	.333	1.23	4.10	2	3
	OCCUPATIONAL THERAPIST	5	3.00	1.000	.447	1.76	4.24	2	4
	PSYCHOLOGIST	2	2.50	.707	.500	-3.85	8.85	2	3
	NURSE	14	2.79	1.122	.300	2.14	3.43	1	5
	Total	34	2.50	1.080	.185	2.12	2.88	1	5
question 12	PSYCHIATRIST	10	4.00	.816	.258	3.42	4.58	2	5
	SOCIAL WORKER	3	3.67	.577	.333	2.23	5.10	3	4
	OCCUPATIONAL THERAPIST	5	4.60	.548	.245	3.92	5.28	4	5
	PSYCHOLOGIST	2	4.50	.707	.500	-1.85	10.85	4	5
	NURSE	14	4.29	.469	.125	4.02	4.56	4	5
	Total	34	4.21	.641	.110	3.98	4.43	2	5
question 13	PSYCHIATRIST	10	3.80	.919	.291	3.14	4.46	3	5
	SOCIAL WORKER	3	3.33	.577	.333	1.90	4.77	3	4
	OCCUPATIONAL THERAPIST	5	3.40	.548	.245	2.72	4.08	3	4
	PSYCHOLOGIST	2	4.00	1.414	1.000	-8.71	16.71	3	5
	NURSE	14	3.43	.646	.173	3.06	3.80	3	5
	Total	34	3.56	.746	.128	3.30	3.82	3	5
question 14	PSYCHIATRIST	10	2.30	.675	.213	1.82	2.78	1	3
	SOCIAL WORKER	3	2.67	.577	.333	1.23	4.10	2	3
	OCCUPATIONAL THERAPIST	5	3.00	.707	.316	2.12	3.88	2	4
	PSYCHOLOGIST	2	2.50	.707	.500	-3.85	8.85	2	3
	NURSE	14	2.14	1.027	.275	1.55	2.74	1	4
	Total	34	2.38	.853	.146	2.08	2.68	1	4
question 15	PSYCHIATRIST	10	1.90	.568	.180	1.49	2.31	1	3
	SOCIAL WORKER	3	2.00	.000	.000	2.00	2.00	2	2
	OCCUPATIONAL THERAPIST	5	2.00	.000	.000	2.00	2.00	2	2
	NURSE	14	1.86	.663	.177	1.47	2.24	1	3
	Total	34	1.91	.570	.098	1.71	2.11	1	3

ANOVA

		Sum of Squares	df	Mean Square	F	Sig.
question 1	Between Groups	.963	4	.241	.258	.902
	Within Groups	27.067	29	.933		
	Total	28.029	33			
question 2	Between Groups	2.142	4	.536	1.084	.383
	Within Groups	14.329	29	.494		
	Total	16.471	33			
question 3	Between Groups	10.204	4	2.551	2.572	.059
	Within Groups	28.767	29	.992		
	Total	38.971	33			
question 4	Between Groups	8.335	4	2.084	2.220	.091
	Within Groups	27.224	29	.939		
	Total	35.559	33			
question 5	Between Groups	4.476	4	1.119	.676	.614
	Within Groups	48.024	29	1.656		
	Total	52.500	33			
question 6	Between Groups	4.136	4	1.034	.747	.568
	Within Groups	40.129	29	1.384		
	Total	44.265	33			
question 7	Between Groups	4.425	4	1.106	1.461	.240
	Within Groups	21.957	29	.757		
	Total	26.382	33			
question 8	Between Groups	3.271	4	.818	1.044	.402
	Within Groups	22.729	29	.784		
	Total	26.000	33			
question 9	Between Groups	4.690	4	1.172	.888	.483
	Within Groups	38.281	29	1.320		
	Total	42.971	33			
question 10	Between Groups	7.456	4	1.864	1.863	.144
	Within Groups	29.014	29	1.000		
	Total	36.471	33			
question 11	Between Groups	7.376	4	1.844	1.718	.173
	Within Groups	31.124	29	1.073		
	Total	38.500	33			
question 12	Between Groups	2.335	4	.584	1.508	.226
	Within Groups	11.224	29	.387		
	Total	13.559	33			
question 13	Between Groups	1.487	4	.372	.638	.639
	Within Groups	16.895	29	.583		
	Total	18.382	33			
question 14	Between Groups	3.048	4	.762	1.053	.397
	Within Groups	20.981	29	.723		
	Total	24.029	33			
question 15	Between Groups	.121	4	.030	.083	.987
	Within Groups	10.614	29	.366		
	Total	10.735	33			